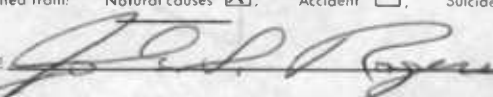
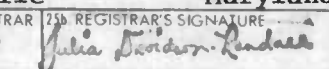


075971 DEC 23 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36039

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ernest W. Absher			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12/14 19 87		2b. HOUR M
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Oct. 31, 1916	6. AGE (IN YEARS) (LAST BIRTHDAY) 71 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 71 YRS.	IF UNDER 24 HRS. 71 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County		MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4524 Randolph Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	
12b. KIND OF BUSINESS OR INDUSTRY Trucking					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 4524 Randolph Road	
14. FATHER'S NAME FIRST MIDDLE LAST William Smith Absher			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Lee Lewis		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT Sharon L. Leeland	
16c. ADDRESS 2696 Walston Road		16d. ADDRESS Mt. Airy, Md. 21771			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic emphysema.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None					
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE 		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS Silver Spring, Montgomery County, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 18, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	
23d. LOCATION CITY OR TOWN Rockville		COUNTY Maryland		STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/		300 West Montgomery Ave. Rockville, Maryland 20850		25a. DATE REC'D. BY REGISTRAR DEC 22 1987	
25b. REGISTRAR'S SIGNATURE 					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (5))

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Handwritten text, possibly a signature or name, written vertically.

000 38 030

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1- STATE
REGISTRAR

87 REG. NO. 36040

4. DECEASED NAME (TYPE OR PRINT) CLAYTON BRADFORD ADAMS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 2, 1987		2b. HOUR MIN 5:15 a
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 27, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oregon	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comm. Spec.		12b. KIND OF BUSINESS OR INDUSTRY U S Air Force
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) a. STATE VIRGINIA	13b. COUNTY Fairfax	13c. CITY OR TOWN FAIRFAX	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 12314 WASHINGTON BRICE RD 22033	
14. FATHER'S NAME FIRST MIDDLE LAST Robert E. Adams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Hoffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 543-20-7943	17. INFORMANT ADDRESS MRS. RUTH E. ADAMS (WIFE) SAME AS ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SARCOMA					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS					2 mos.
DUE TO, OR AS A CONSEQUENCE OF (c) RESPIRATORY FAILURE					5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DEC. 2, 1987 , to DEC. 2, 1987 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DEC. 2, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>William P. Keen</i>		DEGREE <i>Clinical Associate</i>		22c. DATE SIGNED 12/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAAS		22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20896			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12/3/87	23c. NAME OF CEMETERY OR CREMATORY Everly F H Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Va.	
24. FUNERAL DIRECTOR NAME Everly Funeral Home		10565 Main St Fairfax, VA		25. DATE REC'D BY REGISTRAR DEC 09 1987	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
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074670 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36041

FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST THOMAS SCOTT ADAMS		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 3, 1987		2b. HOUR 5:40/AM	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 1, 1932		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) LOUISIANA		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH DERWOOD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7620 DEW WOOD DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN DERWOOD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 7620 DEW WOOD DR. / 20855		14. FATHER'S NAME FIRST MIDDLE LAST THOMAS SCOTT ADAMS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMANDA - CARRIERE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. KOREAN CONFLICT 579-36-9923		17. INFORMANT ADDRESS MRS. JOANNE ADAMS (WIFE) SAME AS #13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Small cell carcinoma of right lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>liver lung, bone metastases; COPD, HTN</u>							
19a. DATE OF OPERATION <u>Dec 2, 1987</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) the hospital attended the deceased from <u>Dec 2, 1987</u> to <u>Dec 3, 1987</u> , the (b) last day the deceased alive on <u>Dec 2, 1987</u> , and that in (my) <u>best</u> opinion death occurred on the date and hour and from the causes stated above. (c) I did not view the body after death.							
22b. SIGNATURE <u>Donald E. Dillon</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED DEC. 3 / 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E. DILLON, MD.				22e. ADDRESS 2901 OLNEY SANDY SPRING RD. OLNEY, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 4, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG Co MARYLAND	
24 FUNERAL DIRECTOR NAME W.W. CHAMBERS CO., INC.				25. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE DEC 9 1987 <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 35042					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Janet Elizabeth Adkinson ADKINSON				2a. DATE OF DEATH MONTH DAY YEAR December 13, 1987				2b. HOUR 5:00AM	
3 SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 13, 1987		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2 20		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13111 Glen Mill Road 20850	
14. FATHER'S NAME FIRST MIDDLE LAST Jeffery Lane Adkinson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda Lee Sycalik					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS Geo. Simmons (Grandfather) same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/13/87, 19, to 12/13, 19, 87, that (I) (we) lost saw the deceased alive on 12/13, 19, 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Katherine C. White MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 12-14-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHERINE C. WHITE MD				22e. ADDRESS 9901 Medical Center Drive Rockville, Md. 20850					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/87		23c. NAME OF CEMETERY OR CREMATORY Beech Woods Cemetery		23d. LOCATION CITY OR TOWN Falls Creek, Pennsylvania			
24. FUNERAL DIRECTOR NAME 1331 Rockville Pike Tyson Wheeler Rockville Pike Rockville MD Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR DEC 18 1987		25b. REGISTRAR'S SIGNATURE John [Signature]			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 6 0 4 3
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST Ellen N. Aggers		2a. DATE OF DEATH MONTH DAY YEAR December 21, 1987		2b. HOUR 7:00A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 17, 1929	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Banner Glass INC.			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Ira S. Nichols		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janette E. Edwards		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-36-0341		17. INFORMANT ADDRESS Robert C. Aggers II 6007 Ryland Dr. Bethesda, Md. 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Endometrial Carcinoma with distant metastases</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>12/8</u> , 19 <u>87</u> , to <u>12/8</u> , 19 <u>87</u> that (1) <u>lost</u> saw the deceased alive on <u>12/8</u> , 19 <u>87</u> , and that in my <u>best</u> opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert C. Macon</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Robert C. Macon		22e. ADDRESS 800 Viers Mill Rd. Rockville, Md. 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.	
24. FUNERAL DIRECTOR Davidson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md 20852		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		25a. DATE REC'D. BY REGISTRAR DEC 28 1987	
		25b. REGISTRAR'S SIGNATURE <u>John A. ...</u>			

Cleared by J. Francis Mayle 12/23/87 4:05 PM

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 472 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR
CLARENCE ALBRIGHT					DECEMBER 27, 1987				4:30 pm
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
MALE		CAUCASIAN		MONTH DAY YEAR SEPT 29 1906		81 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		5206 IROQUOIS ROAD 20816				ARMY MAP SERVICE		U.S. GOVERNMENT	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		MONTGOMERY		BETHESDA		YES <input type="checkbox"/> NO <input type="checkbox"/>		5206 IROQUOIS ROAD 20816	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST MOSE ALBRIGHT			FIRST MIDDLE LAST MARY HARPER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
NO			573-28-3416			MARGARET E. ALBRIGHT/WIFE/SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Cardio Respiratory Failure</u>									acute
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Insufficiency</u>									chronic
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema</u>									chronic
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Arteriosclerotic Heart Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> 19 <u>72</u> , to <u>12/29</u> 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>12/27</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Frank J. Fedor</u> DEGREE <u>MD</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/29/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>FRANK FEDOR</u>						22e. ADDRESS <u>4201 CATHEDRAL AVE. WASHINGTON, DC</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			DEC 31, 1987		MT. OLIVET CEMETERY		WASHINGTON, D.C.		
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS, JR.</u>						25a. DATE REC'D. BY REGISTRAR <u>JAN 4 1988</u>			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						REGISTRAR'S SIGNATURE			

BP

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075374 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM NEW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 77 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 0 4 5

1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. DATE OF ESTI- MATED DEATH										7a. HOUR																																																											
1. DECEASED NAME (TYPE OR PRINT)										2c. DATE KNOWN OF DEATH										2d. DATE OF ESTI- MATED DEATH										7b. HOUR																																																											
ALIRIO ALLAN ALEJO										12-11-87										12-11-87										11:30 P M																																																											
3 SEX										4 RACE										5 DATE OF BIRTH										6 AGE (IN YEARS)										IF UNDER 1 YR.										IF UNDER 24 HRS.																																							
male										CAUCASIAN										8-15-12										75										MONTHS										DAYS										HOURS										MIN.																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED										NEVER MARRIED										9. BALTIMORE CITY OR COUNTY OF DEATH																																																	
PHILLIPINES										USA										WIDOWED										DIVORCED										MONTGOMERY																																																	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																																																											
BETHESDA										SUBURBAN HOSPITAL										CARTOGRAPHER										ARMY MAP SER.																																																											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?										13e. STREET ADDRESS																																							
MARYLAND										MONTGOMERY										ROCKVILLE										YES										NO										4427 HALLET STREET 20853																																							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES?										16b. SOCIAL SECURITY NO.										17. INFORMANT										ADDRESS																																							
SEVERIO										ALEJO										IRENE										DOCTORAELERO										NO										577-12-9620										ALICE E. ALEJO/WIFE/SAME AS 13																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										19. CAUSE OF DEATH										20. CAUSE OF DEATH										21. CAUSE OF DEATH										22. CAUSE OF DEATH																																																	
PART I DEATH WAS CAUSED BY:										888 IMMEDIATE CAUSE (a)										Cardio Respiratory arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b)										Sepsis																																																																					
(c)																																																																																									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										Bilateral Subdural Hematomas										Status Post Surgery																																																																					
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?										YES										NO																																																	
21a. EXTERNAL CAUSE WAS UNDERLYING										21b. TIME OF INJURY										21c. HOW INJURY OCCURRED										21d. INJURY OCCURRED										21e. PLACE OF INJURY										21f. LOCATION																																							
OR CONTRIBUTING CAUSE OF DEATH										HOUR A.M. MONTH DAY YEAR										Fall										WHILE										AT HOME										STREET										CITY OR TOWN										COUNTY										STATE									
NOT WHILE										P.M. 10 21 87																				Hosp. tal										8600										Bethesda										Montg.										md																			
AT WORK										AT WORK										Hosp. tal										8600										Bethesda										Montg.										md																													
22a. I certify that I took charge of the remains described above, held an										Autopsy										Inspection										Inquiry										and in my opinion																																																	
death resulted from:										Natural causes										Accident										Suicide										Homicide										Undetermined manner																																							
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED										12-12-87																																																											
John Tauber										M.D. Deputy										MEDICAL EXAMINER										Bethesda md																																																											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										828 Wisconsin Ave																																																																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION										COUNTY										STATE																																							
BURIAL										DEC 17, 1987										GATE OF HEAVEN CEMETERY										SILVER SPRING										MONTGOMERY										MD																																							
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE										25c. REGISTRAR'S SIGNATURE																																																											
FRANCIS J. COLLINS, JR.										DEC 16 1987										Julia																																																																					
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901																																																																																									

07/B4
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DHMH - 17
(VR A15 ME (5))

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AL 5 24

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WROD

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074875 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36046

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH MONROE ALLISON			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 09 87			2b. HOUR MIN 00 05		
3 SEX Male	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 10 17 07 80	6. AGE (IN YEARS) (AT BIRTHDAY) YRS. 50	IF UNDER 1 YR. MONTHS DAYS 00 00	IF UNDER 24 HRS. HOURS MIN 00 00	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 09 1987		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY Co., MD		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5932 RUDYARD DR				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OFFICER		12b. KIND OF BUSINESS OR INDUSTRY US ARMY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE MD	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 5932 RUDYARD DR		20814		
14. FATHER'S NAME FIRST MIDDLE LAST Lafayette Allison			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lacey Rayles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II & Korea 308-03-1036		17. INFORMANT Mercedes L. Allison		ADDRESS same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) INDUR								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I								
19a. DATE OF OPERATION 12/10/87			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? COLLAPSED AT HOME				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:30 P.M. 12 08 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED AT HOME			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5932 RUDYARD DR BETHESDA MONTGOMERY MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Francis C. Mayle			TIME (SPECIFY) Sgt			DATE SIGNED 12/09/87		
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle			ADDRESS 8200 Waco Rd Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1987	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR DEC 11 1987		25b. REGISTRAR'S SIGNATURE Julia Dandridge

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH VITAL RECORDS. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
25MBP
DHMH - 17
(VR A15 ME (5))

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120000H
071003-010100

120000H

071003-010100

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH36047
REG. NO.1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (BY OR PRINT) FIRST MIDDLE LAST MARIA K. AMREIN			2a. DATE OF DEATH MONTH DAY YEAR 12-03-87			2b. HOUR 2:30 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 03 22 19		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hungary		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	

10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Self-employed Worker	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frigyes Kungl		15. MOTHER'S MAIDEN NAME MIDDLE LAST Elizabeth Kummerman		16. STREET ADDRESS / ZIP CODE 7914 Glenbrook Road 20814			

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-32-6318		17. INFORMANT ADDRESS 4905 Cushing Drive Maria A. Perkins (daughter) Kensington, Md. 20895			
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. renal failure, congestive heart failure			
19a. DATE OF OPERATION 6/12/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED coronary artery disease	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 6-11 1987, to 12-3 1987, that (I) (we) last saw the deceased alive on 12-3 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Joann Urgutart MD		22c. DATE SIGNED 12-3-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joann Urgutart		22e. ADDRESS 9711 Medical Center Dr Rockville MD 20855	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR DEC-7 1987		25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

100-33012215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

2. DECEASED NAME
(TYPE OR PRINT)

AUDREA

SCHOLL

ANDERSON

2a. DATE OF DEATH
MONTH DAY YEAR

DECEMBER 4, 1987

2b. HOUR
MIN.

10:20 AM

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

08TH 17TH 1910

6. AGE (IN YEARS LAST BIRTHDAY)

77

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

NEBRASKA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10. CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

9125 KITTELY LANE

12a. USUAL OCCUPATION

HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY

HOME

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

MD.

MONTGOMERY

13b. CITY OR TOWN

BETHESDA

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS / ZIP CODE

9125 KITTELY LANE

20817

14. FATHER'S NAME

PHILIP

AUGUSTIN

SCHOLL

15. MOTHER'S MAIDEN NAME

MARTHA

ZERELDA

HENDERSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

213-48-9299

17. INFORMANT

ADDRESS

Carl A. Anderson Same as item # 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hepatic Failure

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 week

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

(b) Metastatic Breast Cancer

4 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED

IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY

(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from

saw the deceased alive on

above, (I/we) (did) (did not) view the body after death.

and that in (my) (our) opinion death occurred on the date and hour and from the causes stated

22b. SIGNATURE

FREDERICK P. SMITH, MD.

DEGREE

ATTENDING

PHYSICIAN ☐

MEDICAL

DIRECTOR ☐

STAFF

PHYSICIAN ☐

22c. DATE SIGNED

22d. ADDRESS

5401 WESTERN AVE. N.W. WASHINGTON D.C.

23a. BURIAL, CREMATION, REMOVAL

(SPECIFY)

Burial

23b. DATE

12/9/87

23c. NAME OF CEMETERY OR CREMATORY

South Cem.

23d. LOCATION

CITY OR TOWN

Orange, MA

COUNTY

STATE

24. FUNERAL DIRECTOR

NAME

Joseph Gawler's Sons, Inc.

5130 WI Ave. NW Wash., DC 20016

25a. DATE REC'D. BY REGISTRAR

DEC - 9 1987

25b. REGISTRAR'S SIGNATURE

Julia Anderson-Randall

074834 DEC 10 87

10:50 10:50 10:50 10:50 10:50 10:50 10:50 10:50 10:50 10:50

NAME	DATE	TIME	LOCATION	REMARKS
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	
WILLIAM	12/10/87	10:50	U.S.A.	

WILLIAM

WILLIAM

074540 DEC 9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
2- DECEASED NAME (TYPE OR PRINT) Ruth N. APOLENIS									
3- DATE KNOWN OF DEATH 12 3 87 MONTH DAY YEAR									
4- SEX Female									
5- RACE White									
6- DATE OF BIRTH Sept. 19, 1921 MONTH DAY YEAR									
7- AGE (IN YEARS) 66 YRS.									
8- IF UNDER 1 YR. MONTHS DAYS									
9- IF UNDER 24 HRS. HOURS MIN.									
10- DATE PRONOUNCED DEAD 12 3 87 MONTH DAY YEAR									
11- BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.									
12- CITIZEN OF WHAT COUNTRY? USA									
13- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
14- BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD									
15- CITY OR TOWN OF DEATH Rockville									
16- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist									
17- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher									
18- KIND OF BUSINESS OR INDUSTRY County									
19- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
20- STATE Maryland									
21- COUNTY Montgomery									
22- CITY OR TOWN Clarksburg									
23- INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
24- STREET ADDRESS 14316 Sugarloaf Vista Dr. 20871									
25- FATHER'S NAME (TYPE OR PRINT) Pearson H. Hinterleiter									
26- MOTHER'S MAIDEN NAME (TYPE OR PRINT) Dorothy Wean									
27- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No									
28- SOCIAL SECURITY NO. 213-40-9127									
29- INFORMANT ADDRESS Charles J. Apolenis, Item 13									
30- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
31- DATE OF OPERATION									
32- CONDITION FOR WHICH OPERATION WAS PERFORMED?									
33- AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
34- EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH									
35- TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19									
36- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
37- INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>									
38- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
39- LOCATION STREET CITY OR TOWN COUNTY STATE									
40- I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
41- ACTUAL SIGNATURE John Tauber TITLE (SPECIFY) Deputy MEDICAL EXAMINER DATE SIGNED 12-3-87									
42- EXAMINER'S NAME (TYPE OR PRINT) John Tauber ADDRESS 8218 SWISCONSIN AVE									
43- BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation									
44- DATE Dec. 4, 1987									
45- NAME OF CEMETERY OR CREMATORY Westview									
46- LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland									
47- FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.									
48- DATE REC'D. BY REGISTRAR DEC - 8 1987									

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DHMH - 17
(VR A15 ME (5))

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15 2 27 1/2

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- FOR
STATE
REGISTRAR

REG. NO. 36050

DECEASED NAME (TYPE OR PRINT) ALFRED LARS ARONSON			2a. DATE OF DEATH DECEMBER 25, 1987		2b. HOUR 6:00 P.M.
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 27, 1933	6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD		
10 CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor	12b. KIND OF BUSINESS OR INDUSTRY Medicine		
13a. STATE CALIFORNIA		13b. COUNTY	13c. CITY OR TOWN MARINA DEL R.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4139 VIA MARINA #1203, 90292
14 FATHER'S NAME FIRST MIDDLE LAST Louis Aronson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Zwick			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 121-26-8569		17 INFORMANT ADDRESS Mrs. Elizabeth Aronson Wife, Same as Patient	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiopulmonary arrest

DUE TO, OR AS A CONSEQUENCE OF
(b) Liver failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF
(c) Malignant histiocytic lymphoma

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 month

16 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 1, 1987, to DECEMBER 25, 1987, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on DECEMBER 25, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (we) did not view the body after death.			
27b. SIGNATURE <i>[Signature]</i>	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	27c. DATE SIGNED 12/26/87
27d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Rosenberg MD		27e. ADDRESS NATIONAL INSTITUTES OF HEALTH, CC, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-28-87	23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Washington D. C.
24 FUNERAL DIRECTOR NAME MARSHALL'S FUNERAL HOME, INC. 4217 Ninth Street, NW		25a. DATE REC'D. BY REGISTRAR DEC 30 1987	
ADDRESS Washington, D.C.		REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87-36051

REG. NO. 3

1. DECEASED NAME (TYPE OR PRINT) DR. Charles G. Aronstein			2a. DATE OF DEATH MONTH DAY YEAR 12-1-87		2b. HOUR 7:46 A.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH July 16, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION PHYSICIAN	12b. KIND OF BUSINESS OR INDUSTRY GENERAL PRACTICE	
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME ISRAEL GUTMAN ARONSTEIN			15. MOTHER'S MAIDEN NAME TOBA FACA MENDELSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 579-60-1666		17. INFORMANT MOSHE G. ARONSTEIN, 828 BEACH 8th STREET FAR ROCKAWAY, NEW YORK	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/23/87 to 12/1/87, 1987, that (I) found lost saw the deceased alive on 12/2/87, and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did not view the body after death.					
22b. SIGNATURE Alan S. Chanale		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALES		22e. ADDRESS 15225 SHADY GROVE RD, ROCKVILLE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 12/2/1987	23c. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CONGREGATION CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C.	
24. FUNERAL HOME (NAME) DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR DEC 07 1987		25b. REGISTRAR'S SIGNATURE Julia Benison-Budack	
232 CARROLL STREET, N. W., WASHINGTON, D. C.					

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

076281 DEC 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and destroy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

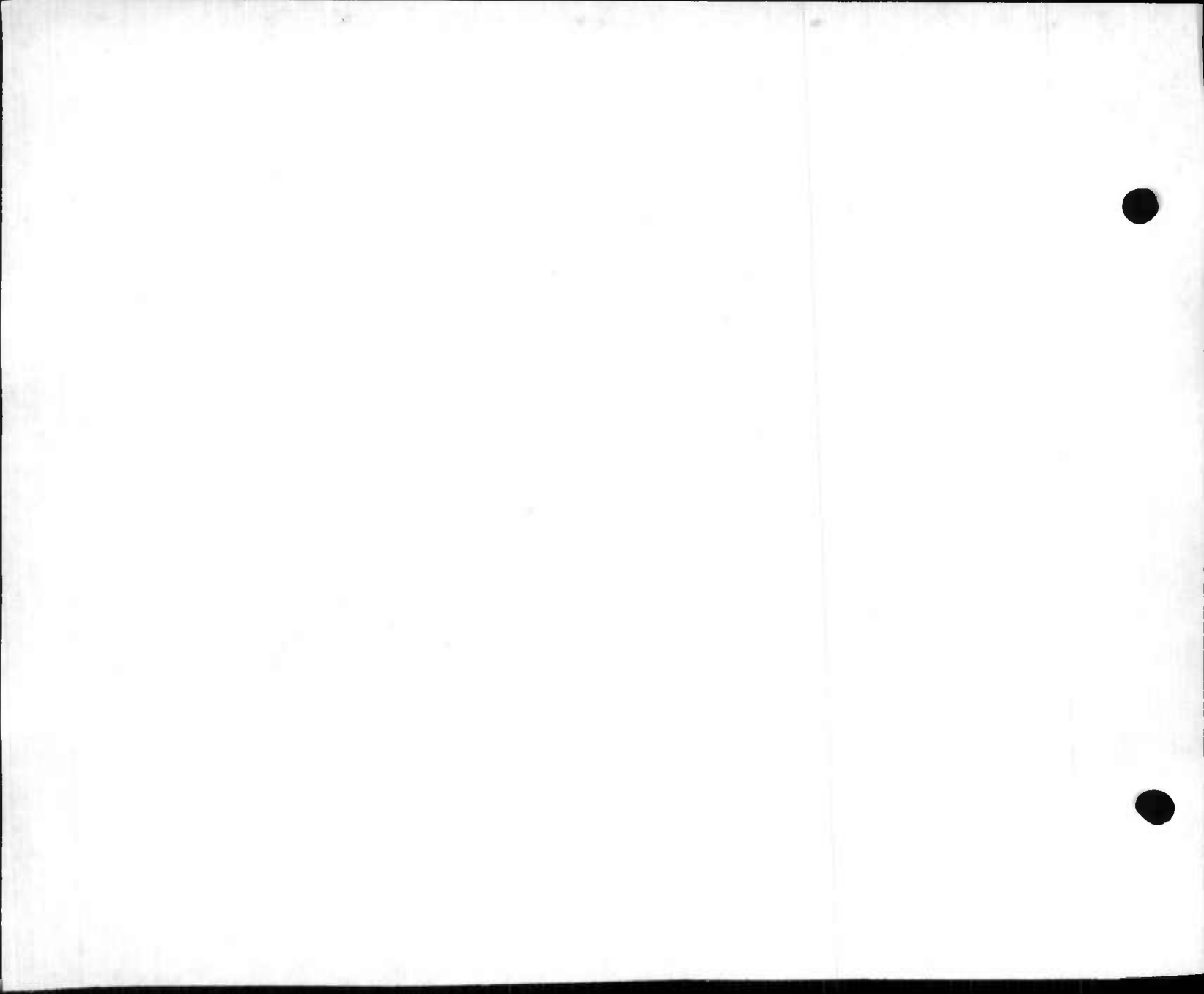
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other trauma, or event, after medical examiner's report, it should be indicated at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DECEASED NAME FIRST <u>Arulanandam</u> MIDDLE <u>Arulsigamoni</u> LAST <u>Arulsigamoni</u>				2a. DATE OF DEATH MONTH <u>12</u> DAY <u>18</u> YEAR <u>87</u>		2b. HOUR <u>2:40</u> P.M.	
3. SEX <u>Male</u>		4. RACE <u>Indian</u>		5. DATE OF BIRTH MONTH <u>11</u> DAY <u>6</u> YEAR <u>22</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>65</u>		IF UNDER 1 YEAR MONTHS <u> </u> DAYS <u> </u> HOURS <u> </u> MIN. <u> </u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>India</u>		7b. CITIZEN OF WHAT COUNTRY? <u>India</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u> MD			
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Psychologist</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Public D.C. Schools</u>	
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Montgomery</u>		13c. CITY OR TOWN <u>Silver Spring</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>502 East indian Spring Drive 20901</u>	
14. FATHER'S NAME FIRST <u>A.</u> MIDDLE <u>Arulsigamoni</u> LAST <u>Arulsigamoni</u>				15. MOTHER'S MAIDEN NAME FIRST <u>Mariamamm</u> MIDDLE <u>(Unknown)</u> LAST <u>(Unknown)</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>		16b. SOCIAL SECURITY NO. <u>220-50-9589</u>		17. INFORMANT ADDRESS <u>180 Mallorca Way Paul Kumar, San Francisco, CA 94123</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO, OR AS A CONSEQUENCE OF (c) <u> </u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>hypertension, diabetes mellitus.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/18</u> , 19 <u>87</u> , to <u>12/18</u> , 19 <u>87</u> that (I) was last saw the deceased alive on <u>12/18</u> , 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) did (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael Lincoln, M.D.</u>				22c. ADDRESS <u>10313 George Lane Silver Spring Md 20902</u>		22d. DATE SIGNED <u>12/18/87</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>12-23-87</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Maryland</u>			
24. FUNERAL DIRECTOR NAME <u>Richard Rapp, Inc.</u> ADDRESS <u>P. O. Box 43352, Washington, DC 20010</u>				25a. DATE REC'D. BY REGISTRAR <u>DEC 24 1987</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

51

VOID

CERTIFICATE # 87 36053



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87-36054
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST FLORENCE A ATKISSON		December 31, 1987		8:15A M	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 26, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Saleslady		12b. KIND OF BUSINESS OR INDUSTRY Department Store
13a. STATE Virginia		13b. COUNTY Fairfax	13c. CITY OR TOWN Vienna	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Stanhope Adams		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Idella Price		16. SOCIAL SECURITY NO. 579-03-5426A	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		17. INFORMANT George B. Atkisson/10194 Hillington Ct. Vienna VA.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Vascular Insufficiency</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/23/1987</u> to <u>12/31/1987</u> , that (I) (we) last saw the deceased alive on <u>12/30/1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.		22b. SIGNATURE <u>Robert C. Macon</u> M.D.		22c. DATE SIGNED 12/31/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert C. Macon M.D.		22e. ADDRESS 809 Viers Mill Rd. Rockville, Md 20857		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE Jan. 4, 1988		23c. NAME OF CEMETERY OR CREMATORY Andrew Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Vienna, Fairfax, Virginia	
24. FUNERAL DIRECTOR NAME Money & King Vienna Funeral Home, Vienna, Va.		ADDRESS 171 W. Maple Ave.		25. DATE REC'D. BY REGISTRAR JAN 5 1988	

JAN 5 1988

076183 DEC 28 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36055

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur G. Ball, Jr.		2a. DATE OF DEATH MONTH DAY YEAR December 22, 1987		2b. HOUR 8:00P M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan 20 1923	
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9212 Adelaide Drive		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
12a. USUAL OCCUPATION (TYPE OF WORK, TRADE, VOCATION, BUSINESS OR INDUSTRY) Technician Engineering		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur G. Ball Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blondy E. Burroughs		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS Pauline L. Ball Wife Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COLON CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> , 19 <u>86</u> , to <u>12/22</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <u>Daniel Rosenblum</u> DEGREE M.D.				22c. DATE SIGNED Dec. 23, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Daniel Rosenblum, M.D.				22e. ADDRESS 10400 Connecticut Avenue Kensington, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Inc. Montgomery Crematorium	
23d. LOCATION CITY OR TOWN Bethesda,		23e. COUNTY Montgomery		23f. STATE Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home NAME Bethesda-Chevy Chase, Inc. 7557 Wisconsin Bethesda, Maryland 20814				25. DATE RECEIVED BY REGISTRAR DEC 24 1987	
				26. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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ROCK BOTTOM LINE

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM #1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSMIT PERMIT #4865 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36056			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Charles C. Ballard</i>										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <i>Dec 2 1987</i>		2b. HOUR <i>4:00 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>OCT-27-1922</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>64 YRS</i>		IF UNDER 1 YR. MONTHS DAYS <i></i>		IF UNDER 24 HRS. HOURS MIN <i></i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pleasant Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Monkton Md.</i>							
10. CITY OR TOWN OF DEATH <i>Tot Pot</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent. Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR AGENCY OR WORKING LIST) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY <i></i>			
13a. STATE <i>Md.</i>				13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Tot Pot</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1012 Heather Ave.</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Freeman Ballard</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>577-09 7200A</i>		17. INFORMANT NAME ADDRESS <i>Marion L. Ballard (Be) 1012 Heather Ave.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>													
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i></i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i></i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i></i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i></i>							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <i>J. H. O. Jones</i>				TITLE (SPECIFY) M.D. <i>Dep.</i>				DATE SIGNED <i>Dec 2-1987</i>					
EXAMINER'S NAME (TYPE OR PRINT) <i>J. H. O. Jones</i>				ADDRESS <i></i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial.</i>		23b. DATE <i>Dec. 7, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Suitland Rd. P. G. Co., Md.</i>					
24. FUNERAL DIRECTOR <i>Takoma Funeral Home, Inc.</i>				25. ADDRESS <i>254 Carroll St. N. W. D.</i>				DATE REC'D. BY REGISTRAR <i>DEC - 4 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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DHMH - 17
(VR A15 ME (5))

0712

DEC 7 1950

Charles C. Ballard

1000 1st St. N.W.
Washington, D.C.

1000 1st St. N.W.
Washington, D.C.

Dear Mr. Ballard:

I have your letter of December 6, 1950, regarding the matter of the proposed new building for the National Bureau of Standards. I am sorry that I cannot give you a more definite answer at this time, but the matter is still under consideration.

I am sure that you will understand the need for a new building for the National Bureau of Standards, and I am sure that you will be satisfied with the results of the proposed new building.

I am sure that you will be satisfied with the results of the proposed new building.

Very truly yours,
John F. Johnson

DEC - 4 1950

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36057

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
David A. Bane						12/ 5/ 19 87						M			
3 SEX	4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR			
Male	White	3-30-70	17 YRS.			12/ 5/ 19 87						1:17 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania			U.S.A.						Montgomery County, MD						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS						
Bethesda Wheaton			Suburban Hospital			Student			Wheaton High School						
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md. Montgomery Wheaton												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3316 Camden St. 20902	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Unknown			Darlene K. Bane			NO			199-54-4463			Darlene K. Bane (mother) 3316 Camden St. Wheaton, Md. 20902			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) Gunshot Wound of Chest															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF															
(b)															
DUE TO, OR AS A CONSEQUENCE OF															
(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
			11:10PM 12/4/ 19 87			subject shot by police									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION			CITY OR TOWN			COUNTY		STATE	
			gas station at			Connecticut Ave. & Aspen, Wheaton, Montg., Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED									
Dennis F. Smyth, M.D.			Assistant			12/6/87									
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION						
Burial			12/11/87			Buckingham Cemetery			Jefferson, Pa.						
24 FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Wheeler Funeral Home, Inc.			DEC 11 1987			Alia Davidson-Randall									
1331 Rockville Pike Rockville, Md. 20852															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07-84
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DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 36058

1 - FOR
STATE
REGISTRAR

1 DECEASED NAME FIRST MIDDLE LAST ABRAHAM BARMINE			2a DATE OF DEATH MONTH DAY YEAR 12/25/87		2b HOUR 1130AM	
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 8 16 99		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russian		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD
10 CITY OR TOWN OF DEATH Rockville, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nsg. Ctr., Rockville, MD		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b KIND OF BUSINESS OR INDUSTRY US Govt.
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Chevy Chase		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Gregory Barmine		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tatiana Gankevich		13e STREET ADDRESS / ZIP CODE 3802 Underwood St., 20815		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) Yes		16b SOCIAL SECURITY NO. WW11		17 INFORMANT ADDRESS Halyna Barmine-wife-(same as 13e)		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke - CVA DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a Urinary Tract Infection						
19a DATE OF OPERATION December 24, 1987		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from November 6, 1987 to December 24, 1987 , that (I) (we) last saw the deceased alive on December 24, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Asad J. Voster, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Dec. 25/87
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS 10,000 Falls Rd., Potomac, MD 20854				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Dec. 28, 1987		23c NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Washington, DC
24 FUNERAL DIRECTOR NAME Hendricks-Rinoldi Funeral Home		ADDRESS 1800 New Hampshire Silver Spring, MD		25a DATE REC'D. BY REGISTRAR DEC 28 1987		25b REGISTRAR'S SIGNATURE Julia Dandrea-Rodman

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078207 JAN 13 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

36059

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA		FIRST MIDDLE LAST BARKSKY		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 27, 1987		2b. HOUR 7:00A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH APRIL 5, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN) POLAND		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN STATE FACILITY, GIVE STREET ADDRESS) 263 CONGRESSIONAL LANE, APT. 504		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN ROCKVILLE				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS ZIP CODE 263 CONGRESSIONAL LANE 20852	
14. FATHER'S NAME FIRST MIDDLE LAST MOSHE SEIDENBERG				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DINA GREENBERG			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 579-28-4788		17. INFORMANT SHIRLEE RICKLIS, 79501 GRENOBLE DRIVE ROCKVILLE, MARYLAND			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Dec 15, 1987, to Dec 27, 1987, that (1) (we) last saw the deceased alive on Dec 15, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did not) view the body after death.							
22b. SIGNATURE Robert Kramer MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. ROBERT KRAMER, M. D.		22e. ADDRESS 10313 GEORGIA AVENUE SUITE 209 SILVER SPRING, MARYLAND					

MEDICAL CERTIFICATION

cleared by DR. FRANCES MAYLE, M. D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to burial, cremation, or entombment with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked correct, then no autopsy, injury, or other traumatic event, the medical examiner must be notified of once.

BP

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/30/1987		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY		23d. LOCATION (CITY OR TOWN) COUNTY STATE ADELPHI, PR. GEO., MARYLAND	
24. DONOR OF ORGAN OR TISSUE NAME ADDRESS DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE	

[The text on this page is extremely faint and illegible. It appears to be a multi-paragraph document, possibly a letter or a report, with several lines of text visible across the page. The content is too faded to transcribe accurately.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36050

1 - FOR
STATE
REGISTRAR

3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 29, 1898			6. AGE (IN YEARS (LAST BIRTHDAY)) 89			7a. DATE OF DEATH MONTH DAY YEAR Dec. 29, 1987			7b. HOUR 8 am					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.											
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4615 N. Park Avenue						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Research Economist						12b. KIND OF BUSINESS OR INDUSTRY University					
13a. STATE MD			13b. COUNTY Montgomery			13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 4615 N. Park Avenue/20815								
14. FATHER'S NAME FIRST MIDDLE LAST Orla Austin Armfield			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Effie C. Clawson						16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 306-42-4678			17. INFORMANT ADDRESS Constance B. Price, Same address as #13.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Aortic Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (a) (this hospital) attended the deceased from 4- 1985 , to 12/29 , 1987 , that (b) (we) lost saw the deceased alive on 12/28 , 1987 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) did not view the body after death.																				
22b. SIGNATURE Robert H. Blee MD						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert H. Blee						22e. ADDRESS 5454 Wisconsin Ave., Chevy Chase, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/5/88			23c. NAME OF CEMETERY OR CREMATORY Elwood City Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Elwood, Indiana											
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.						25. DATE REC'D. BY REGISTRAR JAN 4 - 1988			25b. REGISTRAR'S SIGNATURE John Gordon-Rodden											
24. ADDRESS 5130 Wisconsin Ave, NW, Washington, D.C. 20016																				

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
Case Cleared by M.E. D. Mayle 1/4/88
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 36050 retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-2-60

Dec. 28, 1967

Female	White	May 29, 1908	89
Indiana	U.S.A.	x	Montgomery
Chevy Chase	4015 N. Park Avenue	Research Economic University	
MD	Montgomery	Chevy Chase	x
Orla	Armed	White	C. Clawson
no	---	306-42-4078	Constance B. Price, same address as 306.

x

Robert H. Blee 5-24 Wisconsin Ave., Chevy Chase, MD

730 Wisconsin Ave., N. Washington, D.C. 20016
 Joseph G. Grier's Home, Inc.
 1500 15th St. N.W.
 Wood City Cemetery, Wood, Indiana

077092 JAN -5 88

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 36061

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCY E. BARTOLOMEO			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 28, 1987		2b. HOUR 9:41A M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 10 1911		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10214 HAYWOOD DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EMILIO PALUMBO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TEODOLINDA BUONO			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 215-52-9893	17. INFORMANT ADDRESS SON 6 BEAUVOIR COURT NICHOLAS A. BARTOLOMEO/ROCKVILLE, MD 20855		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY INSUFFICIENCY</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>30 min.</u> <u>10 YEARS</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>DIABETES MELLITUS</u> <u>HYPERTENSION</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Avenue 68 12/28/87	
22a. I certify that (I) (this hospital) attended the deceased from <u>August 1968</u> to <u>12/28/87</u> , that (I) (we) last saw the deceased alive on <u>12/29/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <u>Dr. Hand</u>		DEGREE MD		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. HAND		22e. ADDRESS 4600 CONNECTICUT AVE. WASHINGTON, D.C. #109			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 31, 1987	23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 4 1988			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CLEANED BY DV RODGERS, MEDICAL EXAMINER
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

05-014 2007

075172 DEC 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36062
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LILY BARUKH		2a. DATE OF DEATH MONTH DAY YEAR 12 4 87		2b. HOUR 5:15 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 7 29 18	
6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 74 HRS. MONTHS DAYS HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN) INDIA		9b. CITIZEN OF WHAT COUNTRY? U. S. A.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN WHICH DECEASED RESIDED) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS / ZIP CODE 11732 LOVEJOY STREET 20902	
14. FATHER'S NAME FIRST MIDDLE LAST KELLY SAUL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RACHEL (UNASCERTAINABLE)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 216-86-3973		17. INFORMANT RACHEL LEAF, 19 SHADBARK COURT ROCKVILLE, MARYLAND		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adult respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>mitral valve insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks 2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>glucose-6-phosphate dehydrogenase deficiency, chronic renal insufficiency, stroke</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>10/5/87</u> , 19 <u>87</u> , to <u>12/4</u> , 19 <u>87</u> , that (I) <u>was</u> was saw the deceased alive on <u>12/4</u> , 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> was (did) not view the body after death.			
22b. SIGNATURE <u>Michael A. Lincoln</u>		DEGREE M.D.		22c. DATE SIGNED 12/4/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. LINCOLN, M.D.		22e. ADDRESS 10313 G-4032 Ave Suite 305 Silver Spring Md. 20902			
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 12/6/1987		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON CEMETERY	
23d. LOCATION ADELPHI, PR. GEO., MARYLAND		24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REGISTRAR DEC 09 1987	
25b. REGISTRAR'S SIGNATURE <u>Julia Dickinson-Rodgers</u>					

MEDICAL CERTIFICATION

6
8
35
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1

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please attach all non-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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31-67 FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36063 REG NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours after death. State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Bernard		MIDDLE		LAST Barzune		2a. DATE OF DEATH		MONTH 12		DAY 26		YEAR 87		2b. HOUR 8:10 A		M																	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH 04 DAY 10 YEAR 07				6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.				7. IF UNDER 1 YEAR MONTHS DAYS				8. IF UNDER 22 YRS HOURS MIN.																			
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore Md		9b. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.																											
10. CITY OR TOWN OF DEATH Silver Sp. Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pre Health Care Center																																	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd Bur. Engineering		12b. KIND OF BUSINESS OR INDUSTRY																																	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md																		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 15305 CARROLTON RD. (20853)											
14. FATHER'S NAME FIRST PHILIP						MIDDLE						LAST BARZUNE						15. MOTHER'S MAIDEN NAME FIRST LENA						MIDDLE						LAST SACHS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 578-38-1620						17. INFORMANT DAUGHTER ANITA BLUM: 15305 CARROLTON RD. MARYLAND 20853																							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	<u>ARTERIOSCLEROTIC VASCULAR DISEASE</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause last.</u>	DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC BRAIN SYNDROME, TBS, CVA

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
10/1/68	CHLORIDE	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

<p>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>	<p>21b. TIME OF INJURY</p> <table border="1"> <thead> <tr> <th>HOUR</th> <th>A.M.</th> <th>MONTH</th> <th>DAY</th> <th>YEAR</th> </tr> </thead> <tbody> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td>19</td> </tr> </tbody> </table>	HOUR	A.M.	MONTH	DAY	YEAR		P.M.			19	<p>21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)</p>
HOUR	A.M.	MONTH	DAY	YEAR								
	P.M.			19								

21a. INJURY OCCURRED	21b. PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	21c. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					

27a. I certify that (I) (this hospital) attended the deceased from Jan, 1983, to Dec 16, 1987, that ~~the~~(we) last saw the deceased alive on Dec 16, 1987, and that in (my) ~~own~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~did not~~ view the body after death.

72b. SIGNATURE <i>Bernard A. Joffe</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	72c. DATE SIGNED <i>12-26-87</i>
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27a PHYSICIAN'S NAME (TYPE OR PRINT)	27b ADDRESS
BERNARD A. FITZGERALD	317 UNIVERSITY BLVD EAST SILVER SPRING, MD 20901

BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
BURIAL		12/28/87	B'NAT ISRAEL CONG CEM.	OXEN HILL	PG	MARYLAND
BURIAL DIRECTOR		35a. DATE RECEIVED BY REGISTRAR		35b. REGISTRAR'S SIGNATURE		

70 ROCKVILLE PIKE: ROCKVILLE, MD 20852

MEDICAL CERTIFICATION

or item 18 shows only

1



076036 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36064

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Alvin D. BAUGHMAN</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-18-87</i>		2b. HOUR <i>1525</i> M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 6 1931</i>		
6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>56</i>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse				
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8208 Cedar Street, 20910				
14. FATHER'S NAME FIRST MIDDLE LAST Virgil		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna F. Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Korean 226-36-5825		17. INFORMANT ADDRESS Ella S. Baughman-wife- (same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>prolonged pulmonary involvement</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic cancer lung (osteal)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>12/18/87</i> to <i>12/18/87</i> , that (I) (we) lost <i>9/87</i> <i>87</i> <i>12/18</i> <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Mark D. Weltz</i>		DEGREE		22c. DATE SIGNED <i>12/18/87</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Mark D. Weltz</i>		22e. ADDRESS <i>1525 Greenway Dr. Suite Greenbelt MD 20770</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-1987		23c. NAME OF CEMETERY OR CREMATOR Quantico Natl. Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Quantico Virginia						
24. FUNERAL DIRECTOR NAME <i>HINES RINALDI</i>		11800 N.H. Ave., S.S. Md. Funeral Home		25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1987</i>		
25b. REGISTRAR'S SIGNATURE <i>Julia F. ...</i>						

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

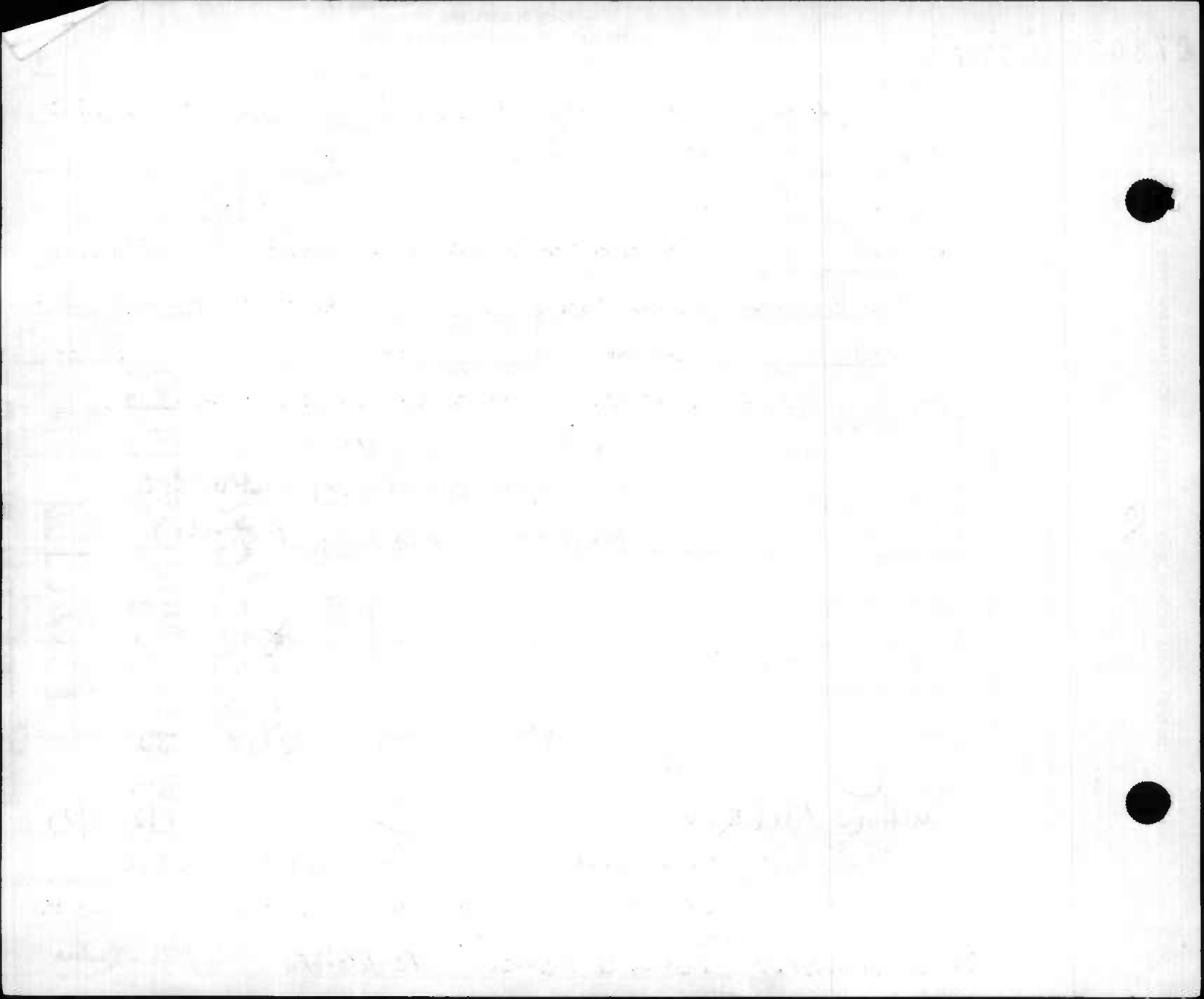
BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



076694 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) ELLA LOUISE BELL					2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24 1987			2b. HOUR 12:30 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 17 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (CITY OR FOREIGN COUNTRY) DISTRICT OF COLUMBIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SERVICE REPRESENTATIVE			12b. KIND OF BUSINESS OR INDUSTRY SOCIAL SECURITY		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 14000 CASTLE BLVD 20904	
14. FATHER'S NAME FIRST MIDDLE LAST HAROLD DARLTON SWEARES, SR.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA MAE SWEENEY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -		17. INFORMANT MILDRED IRBY, RT 1, BOX 60, BRYANS ROAD, MD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC PANCREATIC CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29, 19 87, to DECEMBER 24, 19 87, that (I) (we) last saw the deceased alive on DECEMBER 24, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE T. X. Dwyer LT MC				DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 29 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. X. DWYER, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 28, 1987		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PR. GEO. MARYLAND			
24. FUNERAL DIRECTOR FRANCIS J. COLLINS, JR. NAME ADDRESS 500 UNIVERSITY BLVD., W. SILVER Spring, MD. 20901				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC 30 1987			

1. The first part of the report is a summary of the work done during the year.



2. The second part of the report is a detailed description of the work done during the year.



3. The third part of the report is a summary of the work done during the year.

4.

G. M.

27 3-27-30

P. O.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36066
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GERVAISE H. BELL			2a. DATE OF DEATH MONTH DAY YEAR 12-27-87		2b. HOUR 7:05 PM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR July 13, 1911		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS. MONTHS DAYS HOURS MIN. 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD	13b. COUNTY Montgomery	13c. CITY OR TOWN Wash. DC.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS, ZIP CODE 20008 2029 Connecticut Ave NW	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES H. CAMPOBELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-44-3301	17. INFORMANT ADDRESS Florence Campbell Germantown, MD. 1750 Black Rock Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) terminal myeloidosis DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/26/87 , 19____, to 12/27/87 , 19____, that (I) (we) last saw the deceased alive on 12/27/87 , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Rosquiel Perrezo MD		DEGREE MD		22c. DATE SIGNED 12/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (EXCEPT) Burial		23b. DATE 12-31-87	23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Germantown, Montg. MD
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR JAN 4 1988	
		25b. REGISTRAR'S SIGNATURE [Signature]			

RECEIVED
JAN 11 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE ASSISTANT SECRETARY
FOR AGRICULTURAL AFFAIRS
CIVIL RIGHTS DIVISION
MEMORANDUM
TO: ASSISTANT SECRETARY
FROM: [illegible]
SUBJECT: [illegible]

[Faint, mostly illegible text in the lower half of the page, possibly a continuation of the memorandum or a separate document.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 7 3 6 0 6 7

1 DECEASED NAME (TYPE OR PRINT) Leslie Carl Bell		2a DATE OF DEATH MONTH DAY YEAR 12- 20- 1987		2b HOUR M 11	
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 8- 18- 1909		6 AGE (IN YEARS (LAST BIRTHDAY)) 78	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi	7b CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accounting Ser.		12b KIND OF BUSINESS OR INDUSTRY Red Cross
13a STATE Maryland		13b COUNTY Prince Georges	13c CITY OR TOWN Beltsville	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME (TYPE OR PRINT) Turner Lee Bell		15 MOTHER'S MAIDEN NAME (TYPE OR PRINT) Blanche Booth		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) NO	
16b SOCIAL SECURITY NO. 228-40-8971		17 INFORMANT NAME ADDRESS Wretha J. Bell Same as #13c.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) N/A					
19a DATE OF OPERATION N/A		19b CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from May , 19 67 , to Dec 20 , 19 87 , that (I) (we) last saw the deceased alive on Dec 14 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Joseph E. Smith, Jr.		DEGREE M.D.		22c DATE SIGNED 12/21/87	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph E. Smith, Jr.		22e ADDRESS 4146 Sandy Springs Rd. Burtonsville, Md. 20866			
23a BURIAL, CREMATION, REMOVAL Burial	23b DATE 12-23-1987	23c NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24 FUNERAL DIRECTOR'S NAME Donald Borgwardt		4400 Powder Mill Rd. Beltsville, Md. 20705		25a DATE REC'D. BY REGISTRAR DEC 23 1987	
25b REGISTRAR'S SIGNATURE [Signature]					

SECTION 4887

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1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36068

DECEASED NAME (TYPE OR PRINT) Virginia Elizabeth Bell			2a. DATE OF DEATH MONTH DAY YEAR Dec. 1, 1987		2b. HOUR 8:55P M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 16, 1918		6. AGE (IN YEARS (LAST BIRTHDAY)) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1913 Seminary Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Wrapper.		12b. KIND OF BUSINESS OR INDUSTRY Grocery Store			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1913 Seminary Road 20910			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Ellis Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marjorie Irene Longerbeam				ADDRESS 1913 Seminary Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-14-5426		17. INFORMANT Dorothy V. Bell - Silver Spring, MD 20910							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma urinary bladder</u> 3yrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>9-25</u> 19 <u>87</u> , to <u>12-1</u> 19 <u>87</u> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>11-30</u> 19 <u>87</u> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <u>George F. Sengstack M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED Dec. 2, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George F. Sengstack M.D.				22e. ADDRESS 3929 Ferrara Drive Wheaton, MD. 20906							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/5/87		23c. NAME OF CEMETERY OR CREMATORY Fairview Lutheran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Bolivar, Jefferson, W. Va.					
24. FUNERAL DIRECTOR NAME Eackles-Spencer, F.H. East Washington Harpers Ferry W.VA.25442				25a. DATE REC'D. BY REGISTRAR DEC - 4 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8736069

REG. NO.

FOR
STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST
Rose M Benner

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR
12 25 87 9:55 PM

3. SEX

Female

4. RACE

Cauc.

5. DATE OF BIRTH

MONTH DAY YEAR
Nov. 23 1914

6. AGE (IN YEARS LAST BIRTHDAY)

73 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Wash. D.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County MD

10. CITY OR TOWN OF DEATH

Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Photo Printer

12b. KIND OF BUSINESS OR INDUSTRY

CRown Photo

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland13b. COUNTY
Mont.13c. CITY OR TOWN
Bethesda13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS / ZIP CODE
4998 Battery Lane

20814

14. FATHER'S NAME

FIRST
John

MIDDLE

LAST

Corso

15. MOTHER'S MAIDEN NAME

FIRST
Rosa

MIDDLE

LAST

Delisi

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

577-16-6914

17. INFORMANT

John M. Benner (spouse) same as (13)

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

cardiac arrest

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

med

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

(b) pneumonia: severe hospital water

DUE TO, OR AS A CONSEQUENCE OF

(c) infection

20415

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

diabetic mellitus: AKA @ leg.

19a. DATE OF OPERATION

12/20/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

hemorrhage @ heart

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from Nov, 1960, to July, 1987, that (I) (we) last saw the deceased alive on 25 July, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

John M. Wynn

DEGREE

med

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/20/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

John M. Wynn

22e. ADDRESS

7001 Wisc. Ave Bethesda Md 20814

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Dec. 29, 1987

23c. NAME OF CEMETERY OR CREMATORY

Ft. Lincoln Cem.

23d. LOCATION

Brentwood

COUNTY

Maryland

STATE

Maryland

24. FUNERAL DIRECTOR

NAME

John F. Delisi

ADDRESS

2222 Wisc. Ave. N.W.

25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

JAN 4 1988

John F. Delisi

Fema

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 shall be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH		2c. HOUR	
		FIRST MIDDLE LAST Lacel Eljorie Bergman				MONTH DAY YEAR December 3, 1987		10:30 P M	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 20 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, The Clinical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE So. Carolina		13b. COUNTY Greenville		13c. CITY OR TOWN Greenville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 400 Yorkshire Dr. 99999 29615	
14. FATHER'S NAME FIRST MIDDLE LAST Josiah Talmadge Cox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Thomas					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 241-05-5925		17. INFORMANT ADDRESS Mr. Alvan Bergman, husband, same as pt.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ovarian Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic partial small bowel obstruction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>November 4</u> , 19 <u>87</u> , to <u>December 3</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>December 3</u> , 19 <u>87</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did not view the body after death.									
22b. SIGNATURE <u>William D. Hoffman</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 12-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>William D. Hoffman</u>				22e. ADDRESS National Institutes of Health, Clinical Center, 9000 Rockville Pike, Bethesda, Md. 20892					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Greenville South Carolina			
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814				25. DATE REC'D. BY REGISTRAR DEC - 8 1987					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36071

1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		2b. HOUR	
MARCOS						BERSTEIN		<input checked="" type="checkbox"/>		12 22 1987		10:28 AM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	12/07/17		70 YRS.						12/22 19 87		10:28 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				2e. HOUR	
Chile		Israel						Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF OTHER THAN HOSPITAL, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		SUBURBAN HOSPITAL						Public Rel. Officer		Tel Aviv Univ			
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Israel						-----		49-5 Ramat Gan		YES <input type="checkbox"/> NO <input type="checkbox"/>		Sarah Ahronson 99999	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
David Berstein				Lena Perlovich									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
NO				None		Bethesda, Md. 20817 Virginia Levy; Daughter; 10226 Arizona Circle							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 09:45 P.M. 12 22 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Collapsed At Home					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10226 ARIZONA CIR Bethesda Mont. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Francis C. Mayle				M.D. DEPT.				MEDICAL EXAMINER				12/22/87	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
FRANCIS C. MAYLE, M.D.				8200 Wisconsin Ave.; Bethesda, Md. 20814									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				12/25/87		Rishon Le Zion Cemetery				Israel			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
DANZANSKY-GOLDBERG				DEC 24 1987									
1170 Rockville Pike; Rockville, Md. 20852													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		87		REG. NO. 36072					
19. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Frank A Biggs</u>						20. DATE OF DEATH MONTH DAY YEAR <u>12 30 87</u>		21. HOUR <u>9:38 AM</u>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <u>May 1 1910</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>77</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY</u> MD.			
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>HOLY CROSS HOSPITAL</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Spring Gardener</u>		12b. NAME OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>11477 Columbia Pike</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Alexander A Biggs</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Aleathea Thompson</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Army		17. INFORMANT ADDRESS <u>Grace Biggs (Wife) Same as 13E</u>					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia (blood culture positive gram, Prot. cocci)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Bow - primary site undetermined</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 days</u> <u>6 months</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Massive Anterior-Intestinal Hemorrhage; DIC (Disseminated Intravascular Coagulation Syndrome)</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November 11</u> 19 <u>87</u> , to <u>December 30</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>December 29</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Aaron H. Traim</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>December 30, 1987</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>AARON H. TRAIM MD</u>				22e. ADDRESS <u>8915 Georgia Ave Silver Spring Md 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>1/2/88</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Colesville Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>S.S. Mont. Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u>				ADDRESS <u>11800 New Hamp Ave. S.S. Md.</u>		25. DATE RECEIVED BY REGISTRAR <u>JAN 4 1988</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36073
REG. NO.FOR
1- STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM BINDEMAN		2a. DATE OF DEATH MONTH DAY YEAR 12 11 87		2b. HOUR 6:12 PM	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JULY 3 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) REAL ESTATE INVESTOR		12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN CHEVY CHASE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC BINDEMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH DROBIS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-03-2905	17. INFORMANT WIFE ADDRESS CHEVY CHASE, MD JEAN BINDEMAN: 4701 WILLARD AVE #635; (20815)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>years</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Parkinson's Disease + Rheumatoid Arthritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>12/11/87</u> to <u>12/11/87</u> , that (I) (we) last saw the deceased alive on <u>12/11/87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <u>Jack P. Segal</u>				23b. DATE SIGNED	
23c. PHYSICIAN'S NAME (TYPE OR PRINT) JACK P. SEGAL				23d. ADDRESS CHEVY CHASE MD 20815 5530 Wisconsin Ave	
23e. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23f. DATE 12/14/87		23g. NAME OF CEMETERY OR CREMATORY ADAS ISRAEL CEMETERY	
23h. LOCATION CITY OR TOWN COUNTY STATE S.E. WASHINGTON, D.C.		24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other "accident event," the medical examiner must be notified and a post-mortem examination required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36074

1. FOR STATE REGISTRAR 1-00		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 21, 1949
6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TRINIDAD, W. I.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.		10. CITY OR TOWN OF DEATH SILVER SPRING
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING (YEARS)) OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING
14. FATHER'S NAME FIRST MIDDLE LAST ANEUS - WILLS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MONICA - BERTRAND		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO
16b. SOCIAL SECURITY NO 126-62-3612		17. INFORMANT JENNYLIND JACOB		18. ADDRESS MT. HOPE, TRINIDAD, W. I.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) AIDS DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1: CNS TOXO PLASMOISIS				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22. I certify that (if this hospital) attended the deceased from 12/29 1987 to 12/29 1987, that I (we) lost saw the deceased alive on 12/29 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not) view the body after death.				
23. SIGNATURE MARTORIE VOITH M.D.		24. DEGREE M.D.		25. DATE SIGNED DEC 30, 1987
26. PHYSICIAN'S NAME (TYPE OR PRINT) MARTORIE VOITH, M.D.		27. ADDRESS 5530 WISCONSIN AVE. #1240 CHERRY CHASE, MD.		
28a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		28b. DATE DEC. 30, 1987		28c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY
28d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE PG CO. MARYLAND		29. DATE REC'D. BY REGISTRAR JAN 7 1988		
30. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME		31. ADDRESS SILVER SPRING, M.D.		32. REGISTRAR'S SIGNATURE John L. ...

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John E. Blackman

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36075
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Clarence Blanton Blankenship			2a. DATE OF DEATH MONTH DAY YEAR 12 10 87		2b. HOUR 500 A
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 8 17 11		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cartographer		12b. KIND OF BUSINESS OR INDUSTRY Defence Int. Agency
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Kensington	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST David E. Blankenship		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable L. Price			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 224-14-7596		17. INFORMANT Matilda K. Blankenship same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) Coronary atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF Secondary arteriosclerosis					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. Admitted to hospital, severe pain, lost consciousness					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19____, to 1987 , 19____, that (I) (we) last saw the deceased alive on April 1, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. Stephen Hylbert MD		DEGREE MD		22c. DATE SIGNED Dec. 16, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. Stephen Hylbert, MD		22e. ADDRESS 3000 East Pae Ave			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Lynchburg Virginia					
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		ADDRESS 7557 Wisconsin Ave Bethesda, Maryland 20814		25. DATE REC'D BY REGISTRAR DEC 16 1987	
		26. REGISTRAR'S SIGNATURE Julia Gordon-Ludlow			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Released by DL Meyer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 25 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36076 REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Donald R. Boger			2a. DATE OF DEATH MONTH DAY YEAR December 10, 1987		2b. HOUR 7:55 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 18, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher	12b. KIND OF BUSINESS OR INDUSTRY School	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Damascus	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph I. Boger		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Reynolds			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195-14-0038	17. INFORMANT ADDRESS Jean Baldwin Boger, Item 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Infected leg stump</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>October 24</u> , 19 <u>87</u> , to <u>December 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>December 9</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Barry Hecht</u>			DEGREE <u>MD</u>		22c. DATE SIGNED <u>12/10/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barry Hecht, M. D.			22e. ADDRESS 3941 Ferrara Dr., Wheaton, MD 20906		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE Dec. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.			25a. DATE REC'D. BY REGISTRAR DEC 14 1987		
			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove certificates, pages 1 and 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic or medical condition, the medical examiner must be notified of cause.

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U.S. DEPARTMENT OF AGRICULTURE

075371 DEC 17 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8736077

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) PATRICIA LOUISE BOONE			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 11, 1987		2b. HOUR 0202M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 08 25 48		6. AGE (IN YEARS LAST BIRTHDAY) 39	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA Pk. Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY N.A.S.A.	
13a. STATE MARYLAND		13b. COUNTY PR. GEO.	13c. CITY OR TOWN HYATTSVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND H. BREEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY RUPPERT		13e. STREET ADDRESS / ZIP CODE 7003 GREENVALE PARKWAY 20784	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219 487543		17. INFORMANT JERRY W. BOONE HUSBAND SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LIVER FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hepato renal syndrome DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1130 19 87 to 1211 19 87 that (I) (we) lost saw the deceased person above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard M. Chasen M.D.				22c. DATE SIGNED 12/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. CHASEN		22e. ADDRESS 8901 CARROLL AVENUE TAKOMA PARK, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 14, 1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		24b. ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901		24c. DATE REC'D BY REGISTRAR DEC 16 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event (the medical examiner must be notified at once).

BP

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077618 JAN 18 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36078
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward C Borrego			2a. DATE OF DEATH MONTH DAY YEAR 12 29 87		2b. HOUR 4³⁰ PM
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 9 3 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) COLORADO	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY INTNL OIL
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md	13b. COUNTY montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1316 Fenwick La	
14. FATHER'S NAME FIRST MIDDLE LAST CANDELARIO BORREGO		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST QUIRINA GARCIA			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1943-1945	17. INFORMANT ADDRESS MARY M. BORREGO/WIFE/SAME AS 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 d
DUE TO, OR AS A CONSEQUENCE OF (b) metastatic prostate cancer		5 yr
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a Diabetes			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 12/29 1987 , to 12/29 1987 , that (1) (we) lost saw the deceased alive on 12/29 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Peter Sherer	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 12/29/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE JAN 3, 1988	23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY ALEXANDRIA	23d. LOCATION CITY OR TOWN COUNTY STATE VIRGINIA
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR JAN 7 1988	
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 36079

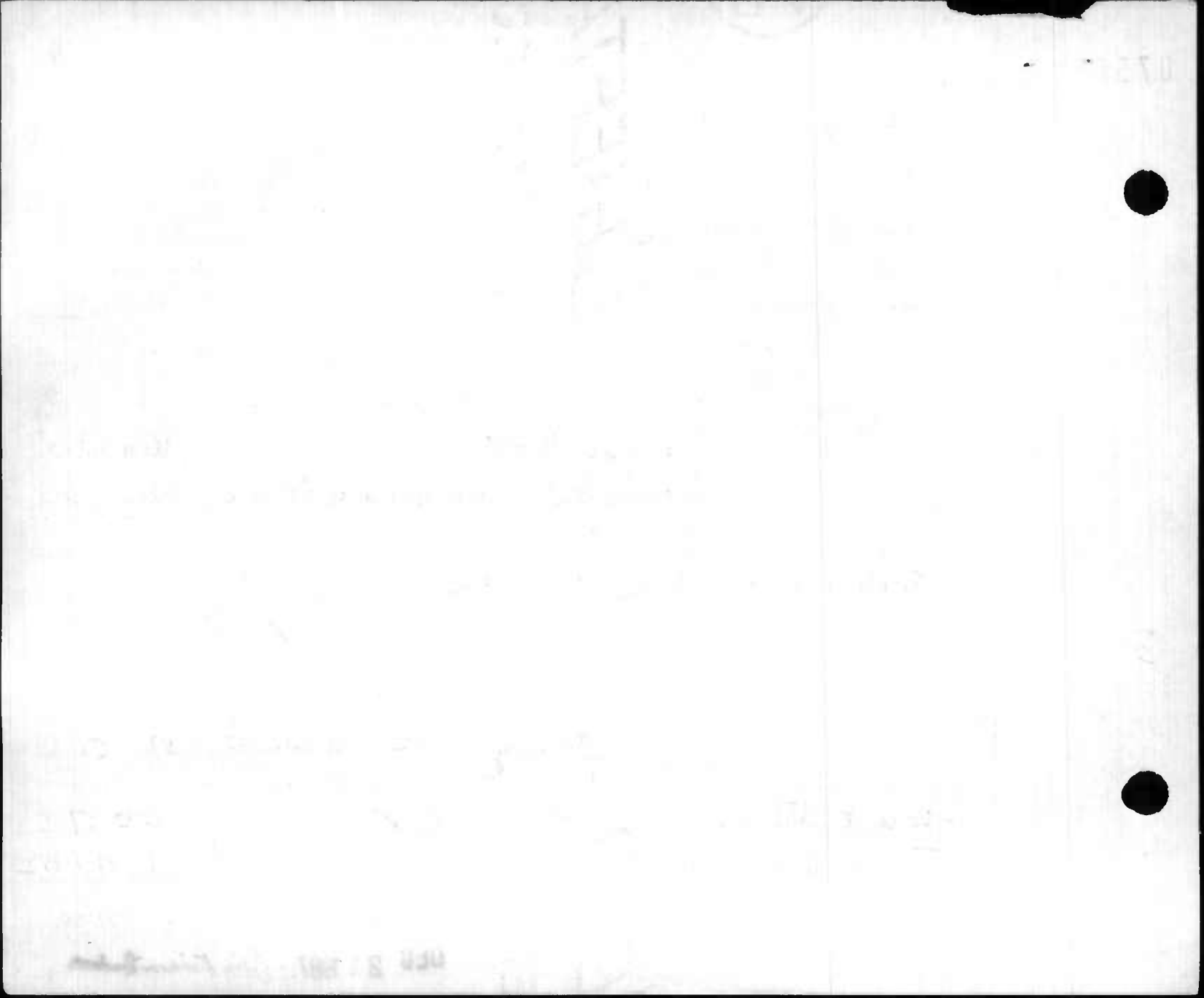
1. DECEASED NAME (TYPE OR PRINT) ETHEL		FIRST LORA		MIDDLE BORSELLINO		LAST		2a. DATE OF DEATH MONTH DECEMBER DAY 12 YEAR 1987		2b. HOUR 2 ^A	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH Nov. DAY 21 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS YRS. DAYS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS / ZIP CODE 14900 Rock Spring Drive				20853							
14. FATHER'S NAME FIRST Henry MIDDLE Benjamin LAST Steel				15. MOTHER'S MAIDEN NAME FIRST Ollie MIDDLE McGawon LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-07-0455		17. INFORMANT SON		ADDRESS 16908 Vine Court Olney, Maryland 20832					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic Cardiovascular disease										many years	
DUE TO, OR AS A CONSEQUENCE OF: (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Senile dementia; chronic Inanition											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from January 19 82 to December 12 19 87 , that (I) (we) last saw the deceased alive on October 30 19 87 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE James E. Wilson, Jr.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) James E. Wilson, Jr. M.D.						22d. ADDRESS 11125 Rockville Pike Ste. 103, Rockville, Md. 20852					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. Geo. Maryland					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.						25a. DATE REC'D. BY REGISTRAR DEC 21 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			
500 University Blvd., W. Silver Spring, Md. 20901											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



075794 DEC 22 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36080

1 DECEASED NAME (TYPE OR PRINT) Wilhelmina L. Bowe			2a. DATE OF DEATH MONTH DAY YEAR 12 15 87		2b. HOUR 900 AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR July 10, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Scientific Illustr		12b. KIND OF BUSINESS OR INDUSTRY Gov't
13a. STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Gaithersburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roger McDougald		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Reese			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 225-38-8128		17. INFORMANT ADDRESS Joseph S. Bowe (husband) #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) melastatic Colon Cancer with APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Suspected Septic Shock and days DUE TO, OR AS A CONSEQUENCE OF (c) Hepatorenal Insufficiency days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/12 19 87 to 12/15 19 87 , that (I) (we) saw the deceased alive on 12/15 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Stephen Newman		DEGREE MD		22c. DATE SIGNED 12/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen Newman, M.D.		22e. ADDRESS 19261 Montg. Village Ave. Gaithersburg, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY Wilkerson Funeral Home Petersburg, Virginia	
24. FUNERAL DIRECTOR NAME George R. Snowden		ADDRESS Rockville, MD 20850		25. DATE REC'D. BY REGISTRAR DEC 18 1987	
		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

075979

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36081
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CORA M BOWIE			2a. DATE OF DEATH MONTH DAY YEAR 12. 18 87		2b. HOUR 4:15 PM
3. SEX FEMALE	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 24 10		6. AGE (IN YEARS LAST BIRTHDAY) 77	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE MD			13b. COUNTY PR. GEO	13c. CITY OR TOWN Cheverly	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John E. Bitting		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Kenepp		16. ADDRESS 6101 Allentown Rd. Suitland, Md. 20746	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-05-5059		17. INFORMANT Joseph J. Garrity	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEPTICEMIA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) X DUE TO, OR AS A CONSEQUENCE OF (c) V					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i) ACUTE RENAL FAILURE (ii) Recent CARDIAC SURGERY FOR AORTIC VALVE					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. X 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) X	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10. 7. 1987 to 12. 18 1987 , that (I) (we) lost saw the deceased alive on 12. 18 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Asif S. Qadri		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 18, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ASIF S. QADRI		22e. ADDRESS 4700 - BERWYN House Rd, College Park, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/21/87	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home		ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25. DATE REC'D. BY REGISTRAR DEC 22 1987	
				25a. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

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DIVISION OF VITAL RECORDS 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF AN DELAY IS NECESSARY, PLEASE
1. AND 2. TO THE FUNERAL DIRECTOR.
3. IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
4. SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
OF RECEIPT OF THIS CERTIFICATE BY THE DIVISION OF VITAL RECORDS, 1001 WASHINGTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36082

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36082							
DECEASED NAME (TYPE OR PRINT)										FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Cecil H. Brathwaite, Sr.																2a. DATE KNOWN OF DEATH				12-26		19		87		1:09 A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD				MONTH		DAY		YEAR		2d. HOUR					
Male		Black		Jan. 10, 1927		60 YRS.		MONTHS		DAYS		Dec. 26,				19		87		1:09 A.M.							
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
New York				United States								Montgomery County				MD											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY															
Silver Spring				Holy Cross Hospital				Lawyer				State Dept.															
13a. STATE										13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS									
Maryland										Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2200 Evans Drive / 20902									
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME																						
Cecil E. Brathwaite					Lillian Parris																						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS																	
No					052-24-3438					Viola R. Brathwaite, Same as 13																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
None																											
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
None																											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																											
ACTUAL SIGNATURE <u>John S. Rogers</u>					TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 12-26-87												
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M. D.					ADDRESS 1919 Seminary Road Silver Spring, MD 20910																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE 12-29-87					23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory					23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland												
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010										25a. DATE REC'D. BY REGISTRAR DEC 30 1987					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>												

John Doe

075653 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36083

1. DECEASED NAME (TYPE OR PRINT) WILLIAM L. BRAY				2a. DATE OF DEATH MONTH DAY YEAR 12 12 87		2b. HOUR 10 A.M.	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 11-28-31		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DISTRIBUTOR		12b. KIND OF BUSINESS OR INDUSTRY ARNOLD BAKERY	
13a. STATE md		13b. COUNTY Mont		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ALPHEUS ELWOOD BRAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FRANCES L. COLLINS		13e. STREET ADDRESS / ZIP CODE 4809 Creek Shore Dr. 20852			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-30-4015		17. INFORMANT ADDRESS LUCIA W. BRAY/WIFE/SAME AS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Leukemia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) myelo dysplasia DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Anemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT IF UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from Sept 19 87 to 12/12 19 87 that (1) (we) lost saw the deceased alive on 12/12 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) did (did not) view the body after death.							
22b. SIGNATURE Peter Sherer MD				DEGREE MD		22c. DATE SIGNED 12/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD				22e. ADDRESS 3947 Ferrara Dr. Wheaton md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 15, 1987		23c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONTGOMERY MARYLAND	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25. DATE REC'D. BY REGISTRAR DEC 21 1987			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				26. REGISTRAR'S SIGNATURE Julia B. [Signature]			

[Faint, mostly illegible handwritten text covering the main body of the page. Some words like "received" and "from" are faintly visible.]

RECEIVED

1900

RECEIVED

1900

77167 JAN -5 88

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

36084

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
		Janet						Brazdionis		12/28		19		87				M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (BY YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female		White		Mar. 11, 1914		73 YRS.						12/28		19		87		2:10 P.		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH									
NEW JERSEY				USA								Montgomery County MD									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY									
Olney				4009 Olney-Laytonsville Road				ADMINISTRATIVE				U.S. GOV.									
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
Maryland				Montgomery				Olney				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20833 4009 Olney-Laytonsville Road					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT					
ADALBERT				CIESIELSKI				MAGDALEN				***				1707 N. St. N. W.					
												137-30-7124				NICHOLAS A. ADDAMS WASHINGTON, D.C. 20036					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																					
(b) <u>chronic myocardial disease.</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
None																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?									
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
				P.M. 19				None													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
								STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																					
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED													
John S. Rogers, M.D.				Deputy				12/29/87													
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
John S. Rogers, M.D.				1919 Seminary Road				Silver Spring, Montgomery County, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
BURIAL				DEC. 31, 1987				GATE OF HEAVEN				SILVER SPRING MONT. MD.									
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
MURIEL H. BARBER				LAYTONSVILLE, MD. 20879				JAN 4 1988													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/B4
25M

BP
DHMH - 17
(VR A15 ME (5))

WAVE

WAVE



WAVE

075944 DEC 23 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36085

1. DECEASED NAME (TYPE OR PRINT) Beulah P. Brewer			2a. DATE OF DEATH MONTH DAY YEAR December 16, 1987		2b. HOUR 1:30 PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 2, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maine		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Treasurer		12b. KIND OF BUSINESS OR INDUSTRY Wesley Seminary		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Byron Brewer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Farnham		13e. STREET ADDRESS / ZIP CODE 403 Russell Avenue #702/20877			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-6628		17. INFORMANT Lilly A. Roberti 2 Stevens Lane Tabernacle, NJ 08088				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Ovarian Carcinoma								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from August 18, 1987, to December 16, 1987, that (I) (we) lost saw the deceased alive on December 16, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John R. Melnick				DEGREE MD		22c. DATE SIGNED 12/16/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John R. Melnick, M.D.				22e. ADDRESS 911 North Russell Avenue Gaithersburg, MD 20879				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Maryland		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey 300 West Montgomery Ave. Rockville, MD 20850				25. DATE REC'D BY REGISTRAR DEC 22 1987				
				26. REGISTRAR'S SIGNATURE Julia Gordon-Randall				

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36086

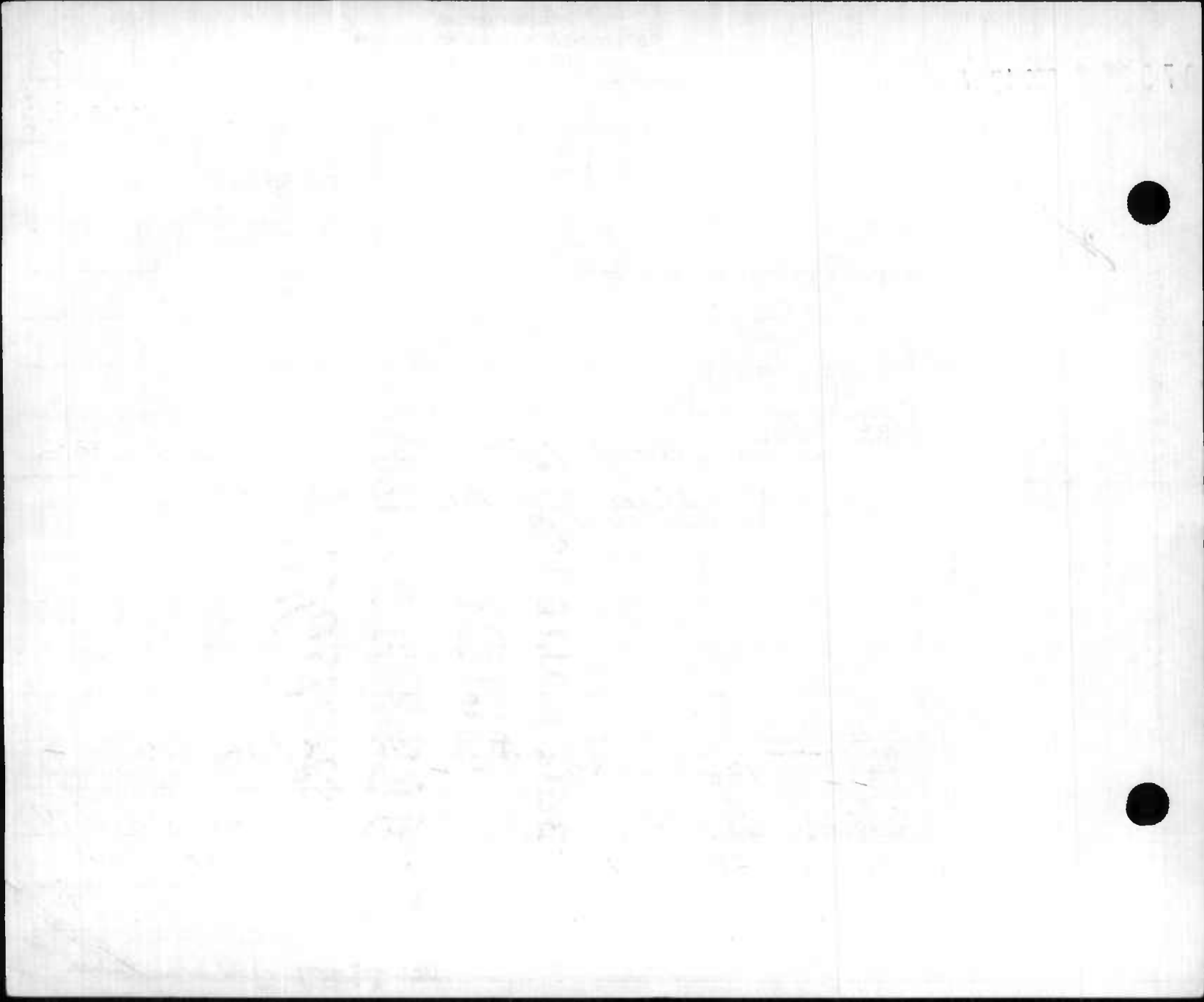
FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CLARK E. Brown		2a. DATE OF DEATH MONTH DAY YEAR 12-12-87		2b. HOUR 2:35 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR February 15, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Private
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Clark E. Brown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine McWilliams			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 114-05-8049		17. INFORMANT ADDRESS Gertrude S. Brown, Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ORGANIC BRAIN SYNDROME</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from <u>4/24</u> 19 <u>87</u> to <u>10/10</u> 19 <u>87</u> , that (I) was last saw the deceased alive on <u>10/10</u> 19 <u>87</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above; (I) was <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <u>Walter E. Goetz</u> DEGREE				22c. DATE SIGNED <u>12/13/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOZH MD				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-14-87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia		24. FUNERAL DIRECTOR NAME Richard Rapp, Inc. ADDRESS P. O. Box 43352, Washington, DC 20010			
25a. DATE REC'D. BY REGISTRAR DEC 16 1987				25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 0 8 7

FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	20. DATE KNOWN OF DEATH ESTI- MATED		21. HOUR
Deborah C. Brown					20. DATE KNOWN OF DEATH ESTI- MATED		21. HOUR
1. SEX		4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	22. DATE PRONOUNCED DEAD
FEMALE		WHITE	JULY 29, 1957	30 YRS.	MONTHS	DAYS	12 31 19 87
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.		WIDOWED		Montgomery County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		OPTICAL ASSISTANT		OPTOMETRY	
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.		MONTGOMERY	GAITHERSBURG	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	19108 RHODES WAY 20879		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.			
L. CILIMBERG		PATRICIA K. CLICK		216-74-9675			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT			
NO		216-74-9675		PATRICIA CILIMBERG (SAME AS ITEM #13)			

18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple drug intoxication
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 30 19 87	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE
	home	5011 Aspen Hill Rd, Silver Spring, Mont, MD.

22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE *John E. Smialek* TITLE (SPECIFY) Chief MEDICAL EXAMINER DATE SIGNED 1/2/88

EXAMINER'S NAME (TYPE OR PRINT) John E. Smialek, M.D. ADDRESS 111 Penn St. Balto., MD.

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
CREMATION	1-2-1988	CHAMBERS CREMATORY	RIVERDALE, P.G.C. Md.
24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
W. W. CHAMBERS CO. INC.	20910 SILVER SPRING, Md.	JAN 7 1988	<i>Julie K. ...</i>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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1950

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36088
REG. NO.

075816 DE 22-87

1. STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT) Joyce Y BROWN		2a. DATE OF DEATH MONTH DAY YEAR 12-15-87		2b. HOUR 1615 M	
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR June 16 1936		6. AGE (IN YEARS (LAST BIRTHDAY)) 51 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Keeper		12b. KIND OF BUSINESS OR INDUSTRY Monty Co. Scheds	
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST ROBERT MIDDLE GAINES LAST GAINES		15. MOTHER'S MAIDEN NAME FIRST GLADYS MIDDLE ROBERTS LAST ROBERTS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 112-28-2575	
17. INFORMANT ADDRESS Joe Brown (Husband) SAME AS #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Lung Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 15 19 87 to Dec 15 19 87 that (I/we) last saw the deceased alive on Dec 15 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Boccia				DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Boccia				22e. ADDRESS 14801 Physicians Ln #271 Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-87		23c. NAME OF CEMETERY OR CREMATORY Quantico Nat'l Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Triangle, Virginia	
24. FUNERAL DIRECTOR NAME George R. Snowden ADDRESS Rockville, MD 20850				25a. DATE REC'D. BY REGISTRAR DEC 18 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rudner	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

075812 DEC 23

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM W-3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36039

1. STATE REGISTRAR										20. DATE KNOWN OF DEATH										21. HOUR																																							
2. DECEASED NAME (TYPE OR PRINT) <i>Walter</i>										3. FIRST										4. MIDDLE										5. LAST <i>Brown Jr</i>																													
3. SEX <i>M</i>										4. RACE <i>Blk</i>										5. DATE OF BIRTH										6. AGE (IN YEARS LAST BIRTHDAY)										7. IF UNDER 1 YR.										8. IF UNDER 24 HRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>										7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>										10. DATE PRONOUNCED DEAD <i>Dec 10, 1987</i>																			
10. CITY OR TOWN OF DEATH <i>Vi. Spg</i>										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>12805 Lx hill Rd. Apt. 102</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Clerk</i>										12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Co. Park, Md.</i>																													
13a. STATE <i>Md</i>										13b. COUNTY <i>Mont</i>										13c. CITY OR TOWN <i>Vi. Spg</i>										13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										13e. STREET ADDRESS <i>12805 Lx hill Rd. Apt 102</i>																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME										16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)										16b. SOCIAL SECURITY NO. <i>214-52-6010</i>										17. INFORMANT ADDRESS <i>Betty Brown (mother) SAME AS #13</i>																			
14. FATHER'S NAME FIRST <i>Walter</i>										14. FATHER'S NAME MIDDLE <i>Brown</i>										14. FATHER'S NAME LAST <i>SR.</i>										15. MOTHER'S MAIDEN NAME FIRST <i>Betty</i>										15. MOTHER'S MAIDEN NAME MIDDLE <i>EVANS</i>										15. MOTHER'S MAIDEN NAME LAST									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Extensive Liver & Renal Dis</i>										18. CAUSE OF DEATH (b) <i>Ethanol</i>										18. CAUSE OF DEATH (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																																																											
19a. DATE OF OPERATION <i>None</i>										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)										21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																											
ACTUAL SIGNATURE <i>George R. Snowden</i>										TITLE (SPECIFY) M.D. <i>Reg</i>										MEDICAL EXAMINER										DATE SIGNED <i>Dec 10, 1987</i>																													
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>										23b. DATE <i>12-16-87</i>										23c. NAME OF CEMETERY OR CREMATORY <i>Quantico Nat'l Cem.</i>										23d. LOCATION CITY OR TOWN COUNTY STATE <i>Triangle, Virginia</i>																													
24. FUNERAL DIRECTOR NAME <i>George R. Snowden</i>										ADDRESS <i>Rockville, MD</i>										25a. DATE REC'D. BY REGISTRAR <i>DEC 15 1987</i>										25b. REGISTRAR'S SIGNATURE <i>A. R. Anderson</i>																													

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

1022-1023-1024

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076218 DEC 20 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36090

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR
		Thomas		P.		Brutscher	Dec. 19 87					P M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) (LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Male	Cauc.	9 18 19	68 YRS.			12 21 19 87					16 09 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Pennsylvania		United States				Montgomery County		MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Rockville		12603 ARDENNES AVE				Printer		U.S. GPO				
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		20851		
MD		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13603 ARDENNES AVE				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Not available				Bridget O'Halloran								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS						
yes				WW 2		173 12 9383		Kathryn A. Blackford, 713 Long Corner Rd. Mt. Airy, Md. 21771				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE INDEF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM P.M. 12 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND ON FLOOR						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12603 ARDENNES AVE ROCKVILLE MONT. MD						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED				
Francis C. Mayle, M.D.				Deputy				Dec. 22, 1987				
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								
Francis C. Mayle, M.D.				8200 Wisconsin Avenue Bethesda, Maryland 20814								

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Dec. 29, 1987	Gate of Heaven Cemetery	Silver Spring,		Maryland
24. FUNERAL DIRECTOR (NAME AND ADDRESS)			25a. DATE REC'D. BY REGISTRAR		
Robert A. Humphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Av., Rockville, Md. 20850			DEC 24 1987		
25b. REGISTRAR'S SIGNATURE					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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(VR A15 ME (1))

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100% COTTON FIBER

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MADE IN U.S.A.

MADE IN U.S.A.



074972 DEC 15 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6091

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
ANDREW P. BUCHALTER						12 07 1987			P			M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR					
Male	Cauc.	March 12, 1952	35 YRS.			12 09 1987			12 04			M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
New York			United States			WIDOWED			DIVORCED			MONTGOMERY County, MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS)			12b. KIND OF BUSINESS OR INDUSTRY								
BETHESDA			3 POOKS HILL RD			Computer Scientist			Computer								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MD			MONTGOMERY			BETHESDA			YES			3 POOKS HILL RD 20814					
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Zachary Buchalter						Joan Fass											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT					
No						Not Avail.						5380 North Grey Mountain Trail Tucson, Arizona					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) GUNSHOT WOUND HEAD																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																	
(b) DEPRESSION																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?					
												YES NO					
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH						21b. TIME OF INJURY						21c. HOW INJURY OCCURRED					
						P.M. 12 07 1987						SHOT IN HEAD					
21d. INJURY OCCURRED WHILE AT WORK						21e. PLACE OF INJURY						21f. LOCATION					
NOT WHILE AT WORK						Home						3 Pooks Hill Rd BETHESDA MONT MD					
22a. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from:																	
Natural causes Accident Suicide Homicide Undetermined manner																	
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED					
Francis C Mayle						DEPT MEDICAL EXAMINER						12/19/87					
EXAMINER'S NAME						ADDRESS						23a. LOCATION					
FRANCIS C MAYLE						8200 Wisconsin Ave BETHESDA MD						CITY OR TOWN COUNTY STATE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY					
Burial						13, 1987						Evergreen Cemetery					
24. FUNERAL DIRECTOR						25. DAY REC'D BY REG. CLERK						26. DATE OF DEATH					
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.						DEC 14 1987						20814					
7557 Wisconsin Ave. Bethesda, Maryland																	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT FORM. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

07/84
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DHMH - 17
(VR A15 ME (5))

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST. BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 along any injury, or other traumatic event, the medical examiner will be notified of course.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 DEC 24 1987 36092

1. DECEASED NAME (TYPE OR PRINT) HARRY W BUCKLEY		2a. DATE OF DEATH MONTH DAY YEAR 12 04 87		2b. HOUR 0835A	
3. SEX MALE	4. RACE CAUCASION	5. DATE OF BIRTH MONTH DAY YEAR 12 01 1910		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN) KSNSAS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY CHEMICAL CO.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MD.	13b. COUNTY MONT.	13c. CITY OR TOWN GAITHERSBURG	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 408 GIRARD ST. 20877	
14. FATHER'S NAME FIRST MIDDLE LAST unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY - UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ****		16b. SOCIAL SECURITY NO. 496-01-2097		17. INFORMANT ADDRESS DAVID L. BUCKLEY SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 8 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Renal failure, Diabetes mellitus, ASHD, Osteoarthritis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he) (this hospital) attended the deceased from Dec 2 19 87 to Dec 4 19 87, that (he) (we) last saw the deceased alive on Dec 3 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (he) (we) (did) (did not) view the body after death.					
23a. SIGNATURE James R. Moore Jr.		DEGREE MD		22c. DATE SIGNED 12-4-87	
23b. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 207 Brookes Ave Gaithersburg Md.			
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23d. DATE DEC. 5, 1987		23e. NAME OF CEMETERY OR CREMATORY BALT. WASH. CREMATORY	
23f. LOCATION CITY OR TOWN COUNTY STATE LAUREL P. GEORGE MD.		24. FUNERAL DIRECTOR NAME ADDRESS MURIEL H. BARBER LAYTONSVILLE, MD. 20879			
25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE DEC - 8 1987 Julia Sinden			

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DEC-8 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

74497 DEC 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36093

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY R. BURCH			2a. DATE OF DEATH MONTH DAY YEAR 12 5 87		2b. HOUR 10:17 P.M.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 8 22 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Golf Pro	
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	12b. KIND OF BUSINESS OR INDUSTRY Country Club
14. FATHER'S NAME FIRST MIDDLE LAST Henry Rubian Burch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Jennings		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-03-3835A		17. INFORMANT ADDRESS Norma A. Burch, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular Fibrillation DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Permanent pacemaker insertion for complete heart block					
19a. DATE OF OPERATION 11/23/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Complete heart block		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) this hospital attended the deceased from 11/23 , 19 87 , to 12/5 , 19 87 , that (I) (we) last saw the deceased alive on 11/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE D.R. Rosing M.D.		DEGREE		22c. DATE SIGNED 12/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D.R. ROSING M.D.		22e. ADDRESS 1125 ROCKVILLE PIKE SUITE 309 ROCKVILLE, MD 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 9, 1987	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814				25a. DATE REC'D. BY REGISTRAR DEC - 8 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

074732 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36094

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Margaret Brennan Burch				December 7, 1987		9:00p M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female	Caucasian	September 23, 1900		87 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Texas	United States			Montgomery County MD			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Potomac Valley Nursing Home		Homemaker		Own Home		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE		
Maryland		Montgomery	Bethesda		7216 Longwood Drive/20817		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Frederick Brennan		Viola Hughes					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		435-70-2619		Margaret Robey 7216 Longwood Drive Bethesda, Maryland 20817 (Daughter)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerosis, generalized</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Senile Dementia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48-72
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atherosclerotic Heart Disease with angina pectoris</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>March 14</u> , 19 <u>69</u> to <u>December 7</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>November 15</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>W. Luther Hall M.D.</u>				DEGREE ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED December 8, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Luther Hall M.D.				22e. ADDRESS 6000 Wisconsin Avenue Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE December 8, 1987		23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda/ Montgomery/Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR DEC 10 1987			
				25b. REGISTRAR'S SIGNATURE <u>John Swickard-Randall</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 0 9 5

1 DECEASED NAME (TYPE OR PRINT) Walter WILLIAM BUSH			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12-16-87			2b. HOUR M											
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Sept. 24, 1922 65		6 AGE (IN YEARS) LAST BIRTHDAY YRS. 65		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12-16-87		2d. HOUR 6:02 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C. United States			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED: <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.								
10. CITY OR TOWN OF DEATH Olney			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery Co. General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed			12b. KIND OF BUSINESS OR INDUSTRY None								
13a. STATE D.C.			13b. COUNTY Montgomery			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET ADDRESS 301 Seaton St. N.E.					
14. FATHER'S NAME FIRST MIDDLE LAST George Bush						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Bush											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes WWII						16b. SOCIAL SECURITY NO. 229-16-3512						17. INFORMANT ADDRESS 3045 Clinton St. N.E.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypothermia complicating Arteriosclerotic cardiovascular disease and senility DUE TO, OR AS A CONSEQUENCE OF (b) cardiovascular disease and senility (c) cardiovascular disease and senility												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Found				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12-16-87				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject exposed to cold									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) rear yard of				21f. LOCATION CITY OR TOWN STREET COUNTY STATE 18236 Becon Hollow Rd. Silver Spring, Md.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 12-17-87				MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell				ADDRESS 111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/22/87				23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l				23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland					
24. FUNERAL DIRECTOR NAME Frazier's Funeral Home				ADDRESS Wash., D.C.				25a. DATE REC'D. BY REGISTRAR DEC 30 1987				25b. REGISTRAR'S SIGNATURE Lia Davidson-Bush					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED FOR BURIAL, TRANSIT, PERMIT, PAGE 2 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36096

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> MONTH ESTI. <input type="checkbox"/> DAY MATED	YEAR	2b. HOUR
Jesse C. Byrd						12/2			19	87	M
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED			MONTH	DAY	YEAR
Male	White	Dec. 31, 1897	89 YRS.			12/2			19	87	12:42 P.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland			USA						Montgomery County MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Adventist Hospital			Ret. Traffic Manager US Govt.					
13a. STATE			13b. COUNTY			13c. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland			Arundel			YES <input type="checkbox"/> NO <input type="checkbox"/>			6349 Genoa Road 20868		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Charles Byrd			Nora Elliott			Yes			WW 1 578-22-7445 A		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:			19. DATE OF OPERATION			20. AUTOPSY?		
(Bro-in-law) 10246 Stratford Ave., Charles W. Howard Fairfax, Va. 22030			888 IMMEDIATE CAUSE (a). Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b). fracture of right hip. DUE TO, OR AS A CONSEQUENCE OF (c).			11/30/87			Fracture of right hip.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)			None			21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 11/28 1987		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			21d. PLACE OF INJURY (STREET, FACTORY, FARM, ETC.)			21e. LOCATION STREET CITY OR TOWN COUNTY STATE			21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		
Fell			Nursing home			Washington, D. C.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .			22b. DATE REC'D. BY REGISTRAR			22c. REGISTRAR'S SIGNATURE			22d. DATE		
12/3/87			11800 N. H. Ave. Silver Spring, Md.			DEC - 7 1987					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			12-7-1987			National Memorial Park			Falls Church Virginia		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. DATE		
Hines/Rinaldi Funeral Home			11800 N. H. Ave. Silver Spring, Md.			DEC - 7 1987					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

710-11 123470

20% COTTON FIBER

MADE IN U.S.A.



076249 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 66097

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTI-MATED			MONTH DAY YEAR			2b. HOUR					
RICHARD F. CALVIRD						X			12 12 19 87			M					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR					
M	W	8/10/49	38 YRS.	MONTHS	DAYS	12 12 19 87			11:47			M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH					
Michigan			USA			X			WIDOWED			Montgomery County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
			Rt. 495 no. Rt. 355			Chef			Restaurant								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE												13b. CITY OR TOWN		13c. STREET ADDRESS			
Michigan												Ypsilanti		8820 Tuttle Hill		48197	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
Sylvester L. Calvird						Anne Seagers											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
(YES, NO, OR UNKNOWN)						(IF YES, GIVE WAR OR DATES)						Mrs. Susan E. Calvird Ypsilanti, Mich.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1 DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple gunshot wounds (handgun)																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES X NO					
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				11:20xx 12-12-87				Shot by police.									
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
				road				Rt. 495 no. Rt. 355 Montgomery, MD									
22a. I certify that I took charge of the remains described above, held an Autopsy X Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner																	
22b. I certify that I took charge of the remains described above, held an Autopsy X Inspection Inquiry and in my opinion death resulted from Natural causes Accident Suicide Homicide Undetermined manner																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
				Deputy Chief				12-13-87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Ann M. Dixon, M.D.				111 Penn St., Balto., MD				21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation				12/17/87				Green Mount Cemetery				Baltimore, Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
MITCHELL-WIEDEFELD HOME, INC.				6500 York Rd.				DEC 24 1987				James Gordon					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE PLACED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

DHMH - 17
(VR A15 ME (5))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Paper 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36098

1. FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Don D Cameron			2a. DATE OF DEATH MONTH DAY YEAR 12 19 87		2b. HOUR 9 30 AM
3. SEX male	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 5 18 04	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TIMEKEEPER	12b. KIND OF BUSINESS OR INDUSTRY GICHNER IRON	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 817 MALCOLM DRIVE 20901
14. FATHER'S NAME FIRST MIDDLE LAST RUSSELL CAMERON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MATTIE BURTON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 578-01-9598	17. INFORMANT ADDRESS HELEN J. CAMERON/WIFE/SAME AS 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (i) (his hospital) attended the deceased from <u>4</u> 19 <u>86</u> , to <u>12/19</u> 19 <u>87</u> , that (i) (we) lost <u>12/19</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (i) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Jay Weiner</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jay Weiner		22e. ADDRESS 4701 Rockville Rd Rockville MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 22, 1987	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGES MD
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.			25a. DATE REC'D. BY REGISTRAR DEC 24 1987		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodwell</u>		

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36099

1. DECEASED NAME (TYPE OR PRINT) Bessie A. Campbell			2a. DATE OF DEATH MONTH DAY YEAR 12-26-87			2b. HOUR 1:00 P.M.	
3. SEX FEMALE	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 10 12 95		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS		7. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN	7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collinswood N.H.		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION				

13a. STATE Md.		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 299 HURLEY AVE 20850	
14. FATHER'S NAME FIRST MIDDLE LAST NEIL D. CAMPBELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALMA PURNIA EARNST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 386-22-4484		17. INFORMANT DOROTHY LILES ADDRESS 5820 LENOX RD., BETHESDA, Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular arterial disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 4 years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes mellitus			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from Aug 1984 to Present, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE James F. Mc Murry Jr MD		22c. DATE SIGNED 12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES F. Mc Murry Jr MD		22e. ADDRESS 6318 Democracy Blvd, Bethesda, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION	23b. DATE 12-28-1987	23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.		25a. DATE REC'D. BY REGISTRAR 20910 JAN 4 1988	
ADDRESS SILVER SPRING, Md.		25b. REGISTRAR'S SIGNATURE John T. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten notes and a table. The table has several columns with headers that are difficult to read but appear to include 'NAME', 'AGE', 'SEX', 'RELIGION', 'EDUCATION', and 'OCCUPATION'. There are several rows of data, some of which are crossed out with a large 'X'.

Handwritten notes and a table. The table has several columns with headers that are difficult to read but appear to include 'NAME', 'AGE', 'SEX', 'RELIGION', 'EDUCATION', and 'OCCUPATION'. There are several rows of data, some of which are crossed out with a large 'X'.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5:373 DEC 17 87

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36100

DECEASED NAME (TYPE OR PRINT) DOMENICO CANALI		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 8, 1987		2b. HOUR 9:10 P M	
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR AUGUST 10, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY	7b. CITIZEN OF WHAT COUNTRY? ITALY	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH WHEATON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2312 CHURCHILL ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEF		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST LUIGI CANALI		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CORINA UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-64-0858		17. INFORMANT SON ADDRESS 89 OAK SHADE ROAD GAITHERSBURG, MD. 20879	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>STOMACH CANCER</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 12</u> , 19 <u>82</u> , to <u>DEC 8</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>DEC 1</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22b. SIGNATURE <i>George Kenton</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED DEC 9, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE KENTON		22e. ADDRESS 10620 GEORGIA AVENUE SUITE 213 SILVER SPRING			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 11, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN	
23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD.		23e. DATE REC'D. BY REGISTRAR DEC 16 1987			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		ADDRESS 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR DEC 16 1987	
		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Rodden</i>			

BP

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DEC 19 1901

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refilled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36101

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Jane Carney</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>DECEMBER 5, 1987</i>		2b. HOUR <i>10:45 am</i>	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>04-30-91</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>96</i>		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Ireland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		10. CITY OR TOWN OF DEATH <i>Olney</i>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Montgomery General Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK AND MOST OF WORKING LIFE) <i>Homemaker</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Rockville</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Murray</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Winifred King</i>		16. SOCIAL SECURITY NO. <i>579-42-4258</i>	
17. INFORMANT <i>William B. Carney Son Same as 13</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>12-1</i> 19 <i>87</i> , to <i>12-5</i> 19 <i>87</i> , that <i>(we)</i> last saw the deceased alive on <i>12-5</i> 19 <i>87</i> , and that in <i>(my)</i> <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above. <i>(We)</i> <i>(did)</i> <i>(did not)</i> view the body after death.					
22b. SIGNATURE <i>J. Howell MD</i>		DEGREE		22c. DATE SIGNED <i>12-5-87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howe, Ted, M.D.</i>		22e. ADDRESS <i>18201 Marden Lane, Olney, Maryland 20832</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Dec. 9, 1987</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington, D.C.</i>		24. FUNERAL DIRECTOR NAME <i>Francis J. Collins, Jr.</i> <i>500 University Blvd. W. Silver Spring, Md. 20901</i>			
25a. DATE DEC'D BY REGISTRAR <i>DEC 11 1987</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>			

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DEC 11 1930

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSE HIDALGO CARRASCOSA									
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPT. 17, 1927		20. DATE OF DEATH MONTH DAY YEAR 12 9 87		21. HOUR 755 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN		7b. CITIZEN OF WHAT COUNTRY? SPAIN		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CHEF		12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 13123 GRENOBLE DR. / 20853	
14. FATHER'S NAME FIRST MIDDLE LAST PEDRO JUAN HIDALGO MARCH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELODIA CARRASCOSA MELIA					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-68-4666		17. INFORMANT Concepcion R. Hidalgo (Wife) Same as # 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MONTHS
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 CEREBRAL EDEMA - CORONARY INSUFFICIENCY									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from July 1 , 19 76 , to Dec 9 , 19 87 , that (I) (we) last saw the deceased alive on December 8 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (do not) view the body after death.									
22b. SIGNATURE Luis Bertolita				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Luis Bertolita MD				22e. ADDRESS 4343 Montgomery Ave - Bethesda - Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec/11/87		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland			
24. FUNERAL DIRECTOR NAME Chambers Funeral Home				ADDRESS Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 15 1987			
				25b. REGISTRAR'S SIGNATURE Julia Denton-Rodriguez					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8736103

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FURREY LEE CARTER				2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 87				2b. HOUR 1100A	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH April DAY 29 YEAR 1930		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS		IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Cabin John		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6404 81st Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Cabin John		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6404 81st Street (20818)	
14. FATHER'S NAME FIRST Carl MIDDLE -- LAST Carter				15. MOTHER'S MAIDEN NAME FIRST Nadine MIDDLE -- LAST Medcalf					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 309 28 8338		17. INFORMANT ADDRESS Same as # 13 above. Gesina Catharina Carter / Wife/					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRAIN TUMOR DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 2 YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED BRAIN TUMOR				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) (the hospital) attended the deceased from APRIL 12 10 , 19 86 , to DEC 20 , 19 87 , that (I) (we) last saw the deceased alive on 12 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Francis C. Mayle						DEGREE MD		22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis C Mayle				22e. ADDRESS 5200 Wisconsin Ave Bethesda MD 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN Alexandria COUNTY Va. STATE 			
24. FUNERAL DIRECTOR NAME Robert A. DeVol ADDRESS 2222 Wisconsin Ave.				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE 			
DeVol Funeral Home				Washington D.C.					

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36104
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Florence CARUSO			2a. DATE OF DEATH MONTH DAY YEAR Dec 24 1987			2b. HOUR 7:30 PM			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MARCH 14, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2948 HEWITT AVE #354				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPER -RET.		12b. KIND OF BUSINESS OR INDUSTRY SERVICE IND.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2948 HEWITT AVE #354 (20906)	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS HOROWITZ			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST PAULINE SOTZSKY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-38-3833		17. INFORMANT HUSBAND ADDRESS SILVER SPRING, MD SALVADOR CARUSO: 2948 HEWITT AVE. #354					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Astrotrophons, Gr. III -TV DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan , 19 87 , to 30 Dec , 19 87 , that (I) (we) last saw the deceased alive on Nov , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Donald E. Dillon MD				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald E. Dillon, M.D.				22e. ADDRESS Olney, MD. 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/27/87		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEM. GARDENS		23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY MONT. MD.			
24. FUNERAL ORGANIZATION 1170 ROCKVILLE PIKE; ROCKVILLE, MD 20852						25a. DATE REC'D. BY REGISTRAR DEC 29 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36105

1. STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HOURS MIN.	
FIRST MIDDLE LAST		December 28, 1987		7:30 pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Caucasian	MONTH DAY YEAR May 30, 1905	82 YRS.	Montgomery County MD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
North Carolina	United States		Registered Nurse		
11. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12b. KIND OF BUSINESS OR INDUSTRY		12c. PRIVATE PRACTICE	
Bethesda	9911 Old Georgetown Road	Private Practice			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Maryland	Montgomery	Bethesda	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9911 Old Georgetown Road/20814	
FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		17. INFORMANT (Husband) ADDRESS	
Robert Bumpass		Mary Dunivent		Dr. John E. Cassidy Same as line #13.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Husband) ADDRESS	
No		579-30-1731		Dr. John E. Cassidy Same as line #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complications of lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>color coins</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>12</u> 19 <u>86</u> to <u>12</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>12/20/87</u> 19 <u>87</u> , and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Sanford Richman, M.D.</u>				December 29, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. REGISTRAR'S SIGNATURE	
Sanford Richman M.D.		11500 Old Georgetown Road Rockville, Maryland 20852		<u>John E. Cassidy</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		December 31,		Gate of Heaven Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Silver Spring, Maryland		JAN 4 1988		<u>John E. Cassidy</u>	
24. FUNERAL DIRECTOR'S NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc.		7557 Wisconsin Avenue Bethesda, Maryland 20814		JAN 4 1988	

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COLLECTOR 1-112-100%

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36106

1. FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST <i>Key Hwa Chang</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12-8-87</i>		2b. HOUR <i>6:10 PM</i>	
3. SEX <i>Female</i>		4. RACE <i>Korean</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 21 14</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Korea</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD	
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>SUBURBAN</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Sales-Drug Fair-Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Potomac</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Chang Lee</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>SSI Lee</i>		13e. STREET ADDRESS / ZIP CODE <i>11405 Beech Grove Lane 20854</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>		16b. SOCIAL SECURITY NO. <i>212 74 1127</i>		17. INFORMANT ADDRESS <i>Nam H. Chang (Son) same as 13E</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pulmonary edema</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>end stage renal disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>diabetic mellitus</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>gastrointestinal coronary artery disease + gastroenteritis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4 Nov 87</i> P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>4 Nov 87</i> , 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>8 Dec 87</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>K. Nossoli MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>K. Nossoli</i>		22e. ADDRESS <i>5620 Shields drive Bethesda MD 20817</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/11/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rockville Mont. Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi</i>		11800 New Hamp. Ave		25a. DATE REC'D. BY REGISTRAR <i>DEC 15 1987</i>		25b. REGISTRAR'S SIGNATURE <i>G. S. M. S. S. M.</i>	

BP

RECEIVED
FEB 10 1963
U.S. DEPT. OF JUSTICE

072130 EC 1803

COMMUNIST PARTY

TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report detailing activities related to the Communist Party in New York.]

6

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075813 DEC 22 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36107	
1- FOR STATE REGISTRAR										2a DATE KNOWN OF DEATH	2b HOUR 1340
DECEASED NAME FIRST MIDDLE LAST Roy RANDOLPH CHASE										2c DATE OF ESTI-MATED MONTH DAY YEAR 12 09 87	2d HOUR 1340
3 SEX M	4 RACE B V	5 DATE OF BIRTH MONTH DAY YEAR 11 07 03	6 AGE (IN YEARS) LAST BIRTHDAY 84 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	2e DATE PRONOUNCED DEAD MONTH DAY YEAR 12 09 87	
10 CITY OR TOWN OF DEATH GAITHERSBURG		11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 8361 FAIRHAVEN DR				12a USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE Unemployed		12b KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a STATE MD	13b COUNTY MONTGOMERY	13c CITY OR TOWN GAITHERSBURG		13e STREET ADDRESS 8361 FAIRHAVEN DR		20811					
14 FATHER'S NAME FIRST MIDDLE LAST Randolph Chase				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNK.							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 316-22-8786		17 INFORMANT James Weedon (son-in-law)		ADDRESS 3008 Flint Hill Adamstown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
DUE TO, OR AS A CONSEQUENCE OF (c) UNDEF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a DATE OF OPERATION											
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?											
20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR A P.M. 12 09 87											
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED AT HOME											
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK											
21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME											
21f LOCATION STREET CITY OR TOWN COUNTY STATE 8361 FAIRHAVEN DR GAITHERSBURG MONTGOMERY MD											
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Francis C. Mayle M.D. TITLE (SPECIFY) DEPT MEDICAL EXAMINER DATE SIGNED 12/09/87											
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle ADDRESS 8200 W. C. W. Ave. Bethesda, MD											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 12-14-87		23c NAME OF CEMETERY OR CREMATORY John Wesley Cem.		23d LOCATION CITY OR TOWN COUNTY STATE Clarksburg, Montg., MD					
24 FUNERAL DIRECTOR NAME George R. Snowden ADDRESS Rockville, MD											
25a DATE REC'D. BY REGISTRAR 20850 DEC 15 1987											
25b REGISTRAR'S SIGNATURE Julia Davidson-Baker											

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076551 DEC 30 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36108

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mae C. Christoffelsz			2a. DATE OF DEATH MONTH DAY YEAR December 24, 1987		2b. HOUR A M 7:15 A
3. SEX Female	4. RACE Burmese	5. DATE OF BIRTH MONTH DAY YEAR October 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Burma	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7904 Deepwell Drive			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. CITY OR TOWN Montgomery	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 7904 Deepwell Drive / 20817	
14. FATHER'S NAME FIRST MIDDLE LAST A. E. Richards		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Swarris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-56-4776	17. INFORMANT ADDRESS Tvonne M. Khin, Same as 13		

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma of lung		22 months
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Pulmonary tuberculosis, Atherosclerotic Cardiovascular Disease			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE 8218 Wisconsin Avenue, Bethesda, MD 20814	
22a. I certify that (I) xxx hospital attended the deceased from February 19 87 to December 24 19 87 , that (I) xxx last saw the deceased alive on December 21 19 87 , and that in my xxx opinion death occurred on the date and hour and from the causes stated above, (I) xxx (did not) view the body after death.			
22b. SIGNATURE Lee R. Pennington, M.D.		DEGREE M.D.	22c. DATE SIGNED 12-24-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lee R. Pennington, M. D.		22e. ADDRESS 8218 Wisconsin Avenue, Bethesda, MD 20814	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12-28-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.		25a. DATE REC'D. BY REGISTRAR DEC 29 1987	
P. O. Box 43352, Washington, DC 20010		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please enclose carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other unusual event, the medical examiner must be notified at once.

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L. R. Pender, MD.

DEC 31 2007

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

87 REG. NO. 36109

2. DECEASED NAME (TYPE OR PRINT) Chung, Im S			2a. DATE OF DEATH MONTH DAY YEAR 12 9 87		2b. HOUR 11 P.M.
3. SEX Female	4. RACE Korean	5. DATE OF BIRTH MONTH DAY YEAR 1 15 03		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Korea	7b. CITIZEN OF WHAT COUNTRY? Korea	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1603 Cedar View Court 20910	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 223-04-2634		17. INFORMANT Silver Spring, MD 20910 K. K. Chung (Son) 1603 Cedar View Court	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Broncho pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11-9 , 19 87 , to 12-9 , 19 87 , that (I) (we) last saw the deceased alive on 11-24 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Tanber		DEGREE MD		22c. DATE SIGNED 12-9-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tanber		22e. ADDRESS 8218 Wisconsin Ave Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/11/87		23c. NAME OF CEMETERY OR CREMATORY National Memorial Park	
23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church VA		23e. DATE REC'D. BY REGISTRAR DEC 15 1987			
24. FUNERAL DIRECTOR NAME Murphy Funeral Home		24b. REGISTRAR'S SIGNATURE Jana Sinden-Radach			
1102 W. Broad St., Falls Church, VA					

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078449 JAN 18 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36110

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
McDONALD		CLAX		DECEMBER 27, 1987		11:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Male	Black	MONTH DAY YEAR July 29, 1948		39 YRS		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
North Carolina		United States		Montgomery County		MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Supervisor/Housekeeping/Hotel			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
District of Columbia		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
4. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
FIRST MIDDLE LAST		FIRST MIDDLE LAST		16b. SOCIAL SECURITY NO.			
Thomas Clax		Flora Hayes		240-82-1737			
17. INFORMANT		Route 2, Box 816; Franklinton, Lorraine Clax (sister) North Carolina					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pneumocystic Pneumonia							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) Acquired Immune Deficiency Syndrome							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Dehydration							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 11, 1987, to December 27, 1987, that (I) (we) lost saw the deceased alive on December 27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Michael Hill				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		Dec. 28, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Michael Hill				Washington, D. C. 20002 1011 North Capitol Street, N.E.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		Jan. 01, 1988		Evergreen Cemetery		North Carolina Franklinton, Franklin County,	
24. FUNERAL DIRECTOR NAME				25. DATE REG. BY REGISTRAR			
LATNEY'S FUNERAL HOME				JAN 14 1988			
3831 Georgia Avenue, N.W.; Washington, D.C. 20011				REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Page 4 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

8 7 3 6 1 1 1

DECEASED NAME (TYPE OR PRINT) Harry L. Claxton			2a. DATE OF DEATH MONTH DAY YEAR Dec. 29 1987		2b. HOUR 7:15 p.m.
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 15 1888		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nursing Home (SS)		12a. USUAL OCCUPATION TYPE OF WORK OR MEANT OF LIVING (INDUSTRY) Pres. R. & W. Claxton Seafood	12b. KIND OF BUSINESS OR INDUSTRY seafood	
13a. STATE N/A			13b. COUNTY N/A	13c. CITY OR TOWN Wash., DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Richard W. Claxton			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Maloney		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 578-05-5448		17. INFORMANT ADDRESS Edward J. Claxton Same as item # 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) 30 YRS.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **PNEUMONIA**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 80 , to 12/29 , 19 87 , that (I) (we) last saw the deceased alive on 12/20 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Kevin G. Nealon		DEGREE M.D.	22c. DATE SIGNED 12/30/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kevin Nealon, M.D.		22e. ADDRESS 916 19th St., N.W., Washington, D.C. 20006	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/2/88	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, MD
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016		25. JAN 4 1988	

Serial 1/2/88
Joseph Pavlenko, Inc.
5150 W. Ave. W. N. H., DC 20016

Order Bill Com.

Switzerland, MD

JAN 1 1988

Kevin Nealon, N.D.

912 12th St., N.W., Washington, D.C. 20006

12/30/87

No

778-00-548

Edward J. Claxton Same as item 13

Richard

W.

Claxton

Henry

Montgomery

N/A

N/A

Wash., DC

x

1980 number 1. W 50015

Silver Spring

Carriage Hill Nursing Home (22)

Claxton

Washington, D.C.

U.S.A.

x

Montgomery County

Male

White

July 15 1888

99

Henry

I.

Claxton

Dec. 29 1987 7:15 p

075337 DEC

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36112

1- STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		7a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		7b. HOUR	
		Paul		J.		Clement, Jr.				Dec 4		19		87		31		P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M		Blk		May 8, 38		49 YRS.						Dec 11		19		87		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
N.C.		U.S.A.		WIDOWED		DIVORCED		Montgomery										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Sil. Spg.		Holy Cross Hosp		Security Guard		Private													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md		Prince Georges		Bethesda		YES		3855 Br 22nd St											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Paul		Lavonia																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
Yes		579-50-3358		Lavonia Clement		920 52nd St., N.E.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
888		Pulmonary Embolus																	
		(b) Ruptured Patellar Tendons & Repairs																	
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO											
Nov 14 87		Ruptured Patellar Tendons		YES															
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. Nov 12 87		Fall at work															
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
		State Dept		Wash		17C													
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
22b. I certify that I took charge of the remains described above, held on		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		MEDICAL EXAMINER		SIGNED											
John S. Rogers, M.D.		1929 Seminary Rd.		Dec 11 1987															
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS																	
John S. Rogers, M.D.		Silver Spring, Md.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
		12/15/87		RIVERDALE PARK		RIVERDALE P.G. Md.													
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
H.S. WASHINGTON & SONS		DEC 16 1987		John Davidson-Randall															
4925 BURROUGHS AVE. N.E.																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMITTING AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

12-7-79 9:33 AM

• 1575000

FOR
STATE
REGISTRAR
per funeral homeSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36113

1. DECEASED NAME (TYPE OR PRINT) FIRST: MAV MIDDLE: BARRY. LAST: CLEMENTS			2a. DATE OF DEATH MONTH: December DAY: 8 YEAR: 87 7b. HOUR: 9:50 PM	
3. SEX F	4. RACE C	5. DATE OF BIRTH MONTH: Feb DAY: 25 YEAR: 1915	6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS. IF UNDER 1 YEAR: MONTHS: DAYS: IF UNDER 24 HRS: HOURS: MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home: 11235 OAK LEAF DR. #1416		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SECRETARY	12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MD 13b. COUNTY: Montgomery 13c. CITY OR TOWN: Silver Spring 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE: 11235 Oak Leaf Dr / 20901				
14. FATHER'S NAME FIRST: JOHN MIDDLE: THOMAS LAST: BARRY		15. MOTHER'S MAIDEN NAME FIRST: VIRGINIA MIDDLE: F. LAST: PAXSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-38-0203	17. INFORMANT Sandra Daughter Address: 22510 Shiloh Church Rd., Boyds, MD 20841		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Pseudobulbar Pa/sy DUE TO, OR AS A CONSEQUENCE OF (c) Squamous Cell Carcinoma of lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 15 yrs 4 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: OSTEO POROSIS + OSTEO ARTHRITIS				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from March 20 19 86 to 8 December 19 87 that (I) (we) last saw the deceased alive on October 19 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Lawrence H. Schrainker M.D.	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9 Dec '87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lawrence H. Schrainker		22e. ADDRESS 5401 Western Ave, N.W.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC 11, 1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY	23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 14 1987		
25c. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove chain markers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other hospital condition, the medical examiner must be notified at once.

BP

076826 DEC 31 1987

22a, Film G636 2/5/88 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6114

1. DECEASED NAME (TYPE OR PRINT) Ronald D. Clipper			2. DATE KNOWN OF DEATH X MONTH DAY YEAR 12/ 17/ 87			7b HOUR M			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1954	6. AGE (IN YEARS) (LAST BIRTHDAY) 33 RS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12/ 17/ 19 87			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 431 Muddy Branch Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer (Ret)		12b. KIND OF BUSINESS OR INDUSTRY State Hwy Com		
13a. STATE Md			13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Arthur G. Clipper			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Mae Jackson			13e. STREET ADDRESS 20876 Apt 431 Muddy Branch Rd, 101			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 579-74-5992		17. INFORMANT ADDRESS Patricia Snowden (Sister) Gaithersburg 110 Bowsprit Court				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Phencyclidine use</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>			TITLE (SPECIFY) Assistant			MEDICAL EXAMINER DATE SIGNED 12/18/87			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-22-87		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Sandy Spring, Montg, MD		
24. FUNERAL DIRECTOR NAME George R. Snowden			24b. ADDRESS 246 N. Washington St. Rockville, MD 20850			25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Snowden</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD, 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M
 BP 958
DHMH - 17
(VR A15 ME (5))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36115

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Lillian A. Clukey

2a. DATE OF DEATH

MONTH

DAY

YEAR

Dec. 31, 1987

2b. HOUR

2:00

a.
M

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
July 5, 1913

6. AGE (IN YEARS LAST BIRTHDAY)

74

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN
COUNTRY)

New York

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hospital

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR
INDUSTRY

Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

12214 Charles Road 20906

14. FATHER'S NAME

(Unknown)

MIDDLE

Columbe

LAST

15. MOTHER'S MAIDEN NAME

Cora

MIDDLE

(Unknown)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

080-03-4275

17. INFORMANT

ADDRESS

Paul A. Clukey (husband) same as 13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Ventricular fibrillation and
cardiac arrestAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Hours.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

arteriosclerotic heart
disease

10 yrs.

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from
12/31/87 to 12/31/87, that (I) (we) last
saw the deceased alive on 12/31/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING
PHYSICIANMEDICAL
DIRECTORSTAFF
PHYSICIAN

22c. DATE SIGNED

12/31/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

B. N. ROSENBAUM

22e. ADDRESS

3720 FARRAGUT AVE.
KENSINGTON, MD. 2089523a. BURIAL, CREMATION, REMOVAL
(SPEC)

Burial

23b. DATE

1/4/88

23c. NAME OF CEMETERY OR CREMATORY

Parklawn Memorial Park

23d. LOCATION
CITY OR TOWN

Rockville, Maryland

24. FUNERAL DIRECTOR

Tyson Wheeler Funeral Home, Inc.
1331 Rockville Pike, Rockville, Md. 20852

25a. DATE REC'D. BY REGISTRAR

JAN 11 1988

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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075010 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36116

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAURA JEAN COBURN			2a. DATE OF DEATH MONTH DAY YEAR DEC. 10 1987		2b. HOUR 1:45 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 10, 1933		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MICHIGAN	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) N.I.H. BETHESDA, MD		12a. USUAL OCCUPATION - (TYPE OF WORK FOR MOST OF WORKING LIFE) CIVIL SERVICE EMPLOYEE U.S. GOV'T		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD		13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DON R. COBURN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET M. LOSEY		16. STREET ADDRESS / ZIP CODE 8858 TAMEBIRD COURT, 21045	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1956-1957 525-82-6890		17. INFORMANT Richard Coburn, ADDRESS: 9789 Hillsmere Rd. Ellicott City, Md. 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Large Cell Lymphoma</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <u>X</u> (this hospital) attended the deceased from <u>SEPTEMBER 18, 1987</u> to <u>DECEMBER 10, 1987</u> , that <u>X</u> (we) last saw the deceased alive on <u>DECEMBER 10, 1987</u> , and that in <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (we) (did) <u>not</u> view the body after death.					
22b. SIGNATURE <u>William D. Hoffman, MD</u>		DEGREE MD		22c. DATE SIGNED 12-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William D. Hoffman, M.D.		22e. ADDRESS NATIONAL INSTITUTE OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/16/87	23c. NAME OF CEMETERY OR CREMATORY ST. JOHN'S EPISCOPAL		23d. LOCATION CITY OR TOWN COUNTY STATE ELLCOTT CITY HOWARD MARYLAND	
24. FUNERAL DIRECTOR LEROY M & RUSSELL C WITZKE FUNERAL HOMES 1630 EDMONDSON AVE CATONSVILLE MD 21228		25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRAR'S SIGNATURE Julia Tindon-Randall	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86117

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethel Wilson Cokkay			20. DATE KNOWN OF DEATH 12/21 19 87			21. HOUR 11:00 M		
2. RACE Female White			3. DATE OF BIRTH Feb. 02, 1916			4. AGE (IN YEARS) 71 YRS.		
5. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			6. CITIZEN OF WHAT COUNTRY? U.S.A.			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		
8. CITY OR TOWN OF DEATH Silver Spring			9. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 9411 Crosby Road			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 21502		
11. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY N 13c. CITY OR TOWN Cumberland			12. STREET ADDRESS 308 Mountain View Drive			13. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME ORION OLIVER WILSON			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			18. SOCIAL SECURITY NO. 217-44-0234			19. INFORMANT		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial disease. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None								
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE John S. Rogers, M.D.			TITLE (SPECIFY) Deputy			DATE SIGNED 12/21/87		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Montgomery County, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal			23b. DATE 12-21-87			23c. NAME OF CEMETERY OR CREMATORY		
24. FUNERAL DIRECTOR NAME State Anatomy Board			ADDRESS Balto., Md.			25a. DATE REC'D. BY REGISTRAR DEC 23 1987		
						25b. REGISTRAR'S SIGNATURE John S. Rogers		

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be forwarded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-plasters. Page 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on duty.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 7 REG. NO. 36118

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY Cohen			2a. DATE OF DEATH MONTH DAY YEAR 12 1 87			2b. HOUR 3:15 PM			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 12, 1920		6. AGE (IN YEARS (LAST BIRTHDAY)) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baker (Retired)		12b. KIND OF BUSINESS OR INDUSTRY Daily Bread	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (20901) 25 East Wayne Avenue, #212	
14. FATHER'S NAME FIRST MIDDLE LAST Meyer Cohen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Gelis				ADDRESS Silver Spring, Md. 20901	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-05-4707		17. INFORMANT Toby Cohen; Wife; 25 E. Wayne Ave., #212;					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction 6 hrs									
DUE TO, OR AS A CONSEQUENCE OF (c) 									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Decemb 1st 87 Decemb 1st 87					
22a. I certify that (I) (this hospital) attended the deceased from Decemb 1st 87 to Decemb 1st 87 , that (I) (we) last saw the deceased alive on Decemb 1st 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE Henry Lyke MD				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Lyke MD				22e. ADDRESS 8830 Cameron St Silver Spring, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/3/87		23c. NAME OF CEMETERY OR CREMATORY B'Nai Israel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				25a. DATE REC'D. BY REGISTRAR DEC - 4 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rosen			
1170 Rockville Pike; Rockville, Md. 20852									

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36119

1. DECEASED NAME (TYPE OR PRINT) IDA COHEN			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1987			2b. HOUR 9"45 ^P _M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 11 30 99		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD NURSING CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT-RET.		12b. KIND OF BUSINESS OR INDUSTRY LADIES WEAR	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7020 HOPEWOOD STREET (20817)	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS GOULD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY GRODMAN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 578-52-3039		17. INFORMANT DAUGHTER		ADDRESS MARYLAND 20817 SHIRLEY COHEN: 7020 HOPEWOOD ST.; BETHESDA.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia - Septic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 week</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASHD; Chronic C.H.F., Osteoporosis, Pyuria</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>12-24</u> 19 <u>87</u> , to <u>12-24</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12-24</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>William Kurstin MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-25-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. WILLIAM KURSTIN				22e. ADDRESS 1145 19th ST. N.W., WASHINGTON, D.C.					
23a. BURIAL, CREMATION, REMOVAL (IMPRINT) BURIAL		23b. DATE 12/27/87		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA			
24. FUNERAL HOME DANZASKY-GOLDBERG MEMORIAL CHAPELS INC 1170 ROCKVILLE PIKE; ROCKVILLE, MD 20852						25a. DATE REC'D. BY REGISTRAR DEC 29 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 2B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36120

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Frederick Coleman Sr.			2a. DATE OF DEATH MONTH DAY YEAR 12 - 13 - 87		2b. HOUR 10:07 A.M.		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR June 3, 1934		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS MONTHS DAYS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fire Chief		12b. KIND OF BUSINESS OR INDUSTRY N.I.H.	
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 1305 Gladstone Drive 20851			
14. FATHER'S NAME FIRST MIDDLE LAST William H. Coleman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Brigham			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 220 28 5258		17. INFORMANT Wife		ADDRESS Patricia A. Coleman Same as item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Acute Lymphocytic Leukemia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Nov. 11 , 19 87 , to Dec. 13 , 19 87 , that (I) (we) last saw the deceased alive on Dec 11 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Jeffrey M. Crane				DEGREE MD		22c. DATE SIGNED	
22b. SIGNATURE Jeffrey M. Crane				22c. ADDRESS 14801 Physicians Lane Suite 271 Rockville, MD 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 16, 1987		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Ave Rockville, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 15 1987		25b. REGISTRAR'S SIGNATURE Julia Barber-Lindner	

BP

010370

12-15-54

1. The first part of the report is a description of the work done during the period from 12-15-54 to 12-15-54. This part of the report is a description of the work done during the period from 12-15-54 to 12-15-54.

2. The second part of the report is a description of the work done during the period from 12-15-54 to 12-15-54. This part of the report is a description of the work done during the period from 12-15-54 to 12-15-54.

3. The third part of the report is a description of the work done during the period from 12-15-54 to 12-15-54. This part of the report is a description of the work done during the period from 12-15-54 to 12-15-54.

DEC 15 1954

075939 DEC 23 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

Cleared by Dr. Tauber
 REG. NO. 87 36121

1. DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-between;"> FIRST Marion MIDDLE J. LAST Collinge </div>			2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> MONTH December DAY 17 YEAR 1987 </div>		2b. HOUR 11:00am						
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH <div style="display: flex; justify-content: space-between;"> MONTH August DAY 23 YEAR 1905 </div>		6. AGE (IN YEARS (LAST BIRTHDAY)) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6100 Wilmett Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Head Cashier		12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6100 Wilmett Road/ 20817		
14. FATHER'S NAME <div style="display: flex; justify-content: space-between;"> FIRST Ernest MIDDLE Guy LAST Miller </div>			15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;"> FIRST Frances MIDDLE J. LAST Mills </div>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577 20 4711	
17. INFORMANT Charles S. Collinge Bethesda, Maryland 20817			ADDRESS 9219 Shelton St.								

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting thoracic atherosclerosis DUE TO, OR AS A CONSEQUENCE OF arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY <div style="display: flex; justify-content: space-between;"> HOUR A.M. 8 MONTH 12 DAY 17 YEAR 1987 </div>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION <div style="display: flex; justify-content: space-between;"> STREET 6100 Wilmett Road CITY OR TOWN Bethesda COUNTY Montgomery STATE MD </div>			
22a. I certify that (1) (this hospital) attended the deceased from 8/14/83 19____, to Present 19____, that (1) (we) lost saw the deceased alive on 8/14/83 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) (tamper) (with) the body after death.							
22b. SIGNATURE Jere J. Daum M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED December 18, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jere J. Daum M.D.		22e. ADDRESS 7505 Democracy Blvd. Bethesda, Maryland 20817					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery		23d. LOCATION <div style="display: flex; justify-content: space-between;"> CITY OR TOWN Suitland, Maryland COUNTY Prince Georges STATE MD </div>	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, INC		24b. ADDRESS 7557 Wisconsin Avenue Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE Julia Gordon-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
 TO HOSPITAL OR ATTENDING PHYSICIAN: The low required that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If item 21 is marked "other," it shows any injury, or other traumatic event, the medical examiner must be notified at once.
 BP
 DHMH - 16 60M 7/84 (VRA 15, 4)

076237

6237 DEC 28 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, a medical examiner must be notified at once.

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36122

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Charles Edgar Condray JR.			2a. DATE OF DEATH MONTH DAY YEAR 12-19-87		2b. HOUR 5:30 A.M.						
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 02 18 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Arkansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carriage Hill Nsg Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Analyst		12b. KIND OF BUSINESS OR INDUSTRY N.S.A.			
13a. STATE Maryland			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Cheverly, MD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 5719 Lockwood Rd. 20785		
14. FATHER'S NAME FIRST MIDDLE LAST Charles E Condray Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Belle Martin			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					
16a. SOCIAL SECURITY NO. 578-32-2564			17. INFORMANT Cordelia Condray			18. Same as #13					
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Dec 7 19 87 to present 19 87 , that (I) (we) last saw the deceased alive on 12/18 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John B. Umhau MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/19/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John B. Umhau MD			22e. ADDRESS 8805 Conn. Ave. Chevy Chase, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 23, 1987			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.		
24. FUNERAL DIRECTOR Francis Gasch's Sons Funeral Home, P.A.			25a. DATE REC'D. BY REGISTRAR DEC 24 1987			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					
4739 Baltimore Ave.			Hyattsville, MD. 20781								

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages 1 and 2 should be filed with the funeral director. Page 4 may be retained by the funeral director. Page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the funeral director must be notified at once.

FOR
STATE
REGISTERARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 3 6 1 2 3

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROLAND OTHO COOLEY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 5, 1987		2b. HOUR 10:15A M		
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR MAY 17 1917		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2902 DAWSON AVENUE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) POLICEMAN		12b. KIND OF BUSINESS OR INDUSTRY MONT. COUNTY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OTHO COOLEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCY SULLIVAN		13e. STREET ADDRESS / ZIP CODE 2902 DAWSON AVENUE 20902		13f. POLICE DEPT.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-07-9935		17. INFORMANT ADDRESS DOROTHY E. COOLEY/WIFE/SAME AS 13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF THE PROSTATE

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 1/2 YRS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/5/87 to 12/5/87, that (I) (we) lost saw the deceased alive on 12/5/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard H. Poley MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Poley MD				22e. ADDRESS 10400 CONNECTICUT AVENUE KENSINGTON, MARYLAND			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 8, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY SILVER SPRING MONTGOMERY MD		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD	
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR.				25a. DATE PREPARED BY REGULAR REGISTRAR SIGNATURE 12/11/87			
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901							

05-608 309-50

075826 DEC 22 87

Item 18a, 20, 21a, b, c, d, e, f, 22a, G335 dw

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

3 6 1 2 4

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		26. HOUR	
Robert						Corbin		20. DATE KNOWN OF DEATH		12-14		19		87		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
MALE	BLACK	9 3 51		36 YRS.		MONTHS		DAYS		12-14		19		87		12:26 a. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
MD		USA		WIDOWED		DIVORCED		Montgomery County,								MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Rockville		Shady Grove Adventist Hospital															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		412 EDGEWOOD STREET 21229									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
HURLEY				CORBIN		EDITH				GREEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
YES		MARINE CORP. 212-56-9880		EDITH CORBIN		412 EDGEWOOD STREET											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Narcotic intoxication		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
				DUE TO, OR AS A CONSEQUENCE OF													
				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-13 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Subject used drugs											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) House		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		19625 Club Lake Road Germantown, Mont. Co., MD.											
22a. I certify that I took charge of the remains described above, held an		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED		12-14-87									
EXAMINER'S NAME (TYPE OR PRINT)		Mario F. Golle, Jr., M.D.		ADDRESS		111 Penn St., Balto., Md. 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE											
BURIAL		12/18/87		GARRISON FOREST VET		OWINGS MILLS MD											
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
WM. C. MARCH F/H		1101 NORTH AVENUE		DEC 18 1987		Julia Davidson-Randall											

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25AADHMH - 17
(VR A15 ME (5))

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20% COTTON FIBER

DMC

WYLLIE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 would be detached for use as the burial/transit permit. Then please return it to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

REG. NO. 36125

1. DECEASED NAME (TYPE OR PRINT) William Bryan Coulter			2a. DATE OF DEATH MONTH DAY YEAR Dec. 28 1987		2b. HOUR 6:45 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 91	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Comptroller		12b. KIND OF BUSINESS OR INDUSTRY Funeral Home
13a. STATE N/A	13b. COUNTY N/A	13c. CITY OR TOWN Wash., DC	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4206 Ingomar St. NW 29999	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Coulter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Propst			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I 577-09-5936	17. INFORMANT ADDRESS Martha Engstler Daughter 5609 Marengo Rd. Beth., MD 20816			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gradiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from July 82 , 19 82 , to Dec. 28 , 19 87 , that (I) (we) last saw the deceased alive on Dec. 10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Jon M. Wiseman</i>		DEGREE MD		22c. DATE SIGNED 12/29/87	
22d. THE PHYSICIAN'S NAME (TYPE OR PRINT) Jon Wiseman		22e. ADDRESS 5410 Connecticut Ave., N.W. Washington, D.C. 20015			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1/2/88	23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc.		25a. DATE REC'D. BY REGISTRAR JAN 4 - 1988		25b. REGISTRAR'S SIGNATURE <i>John E. Wiseman</i>	
ADDRESS 5130 WI Ave. NW Wash., DC 20016					

MEDICAL CERTIFICATION

999999

• 2000-01-01

Grading sheet

Joseph Sawyer's sons, Inc.
I live in... 10 20016

Colville Indian Reservation, Washington

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36126

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Eric Bruce Covington		2a. DATE OF DEATH MONTH 12 DAY 19 YEAR 87		2b. HOUR 2:15 ^A	
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH 7 DAY 28 YEAR 70		6. AGE (IN YEARS LAST BIRTHDAY) 17 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH S.S.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 1508 Rainbow Drive		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST M. MIDDLE Stanley LAST Covington		15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE A. LAST Wallace			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 212 68 7292		17. INFORMANT ADDRESS M. Stanley Covington (Father) Same as 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Osteogenic APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 1 year					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Dec 19 , 19 87 , to Dec 19 , 19 87 , that (I) (we) lost saw the deceased alive on Dec 19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Dr. Lawrence Cohen		DEGREE MD		22c. DATE SIGNED 12/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lawrence Cohen		22e. ADDRESS 10313 Georgia Ave. S.S. Md. Suite 303			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION CITY OR TOWN S.S.		COUNTY Mont.		STATE Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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DEC 23 1961

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES B. COWELL						2a DATE OF DEATH MONTH DAY YEAR DECEMBER 22, 1987		2b HOUR 9:26pm			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR APR. 3, 1903		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 84		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10 CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a STATE Md.			13b COUNTY MONTGOMERY		13c CITY OR TOWN SPENCERVILLE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 1400 SPENCERVILLE RD. 20902		
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b SOCIAL SECURITY NO. 028-01-6909	
17 INFORMANT ADDRESS ANNISE CHAPMAN-STEWART 5630 FISHERS LA. ROCKVILLE, Md. 20852			18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs Approximate interval between onset and death: 5 yrs								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10 yrs											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 12/20 19 87 , to 22 Dec 87 , that (1) (we) last saw the deceased alive on 12/20 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE Lewis Keller MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/22/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis Keller MD			22e. ADDRESS 4000 Olney Laytonsville Rd, Olney, Md. 20832								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION			23b. DATE 12-26, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.		25a. DATE REC'D. BY REGISTRAR 30 1987		
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO. INC.			ADDRESS SILVER SPRING, Md. 20910			25b. REGISTRAR'S SIGNATURE Lia...					

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DATE

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DATE

RECEIVED BY THE DIRECTOR OF THE FBI

FROM THE SAC, NEW YORK (100-100000)

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REC NO. 3 6 1 2 8

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Blanch Cox			2a. DATE OF DEATH MONTH DAY YEAR 12 29 87		2b. HOUR 3:42AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR APRIL 15 1905		
6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ALABAMA		8. AGE IF UNDER 1 YEAR MONTHS DAYS 82		
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS / ZIP CODE 3409 SUNDOWN FARMS WAY 20832		
14. FATHER'S NAME FIRST MIDDLE LAST HENRY L. AYERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY AGNES GILL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		
17. INFORMANT ADDRESS JOHN W. COX, SR./HUSBAND/SAME AS 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystolic cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Epileptic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 min. 4 weeks 1 year		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (c) "Fibrosing Alveolitis 2. Green negative Septic"						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from Dec. 12, 19 87 , to Dec. 29, 19 87 , that (I) (we) lost saw the deceased alive on Dec. 28, 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Frank J. Mayo		DEGREE MD		22c. DATE SIGNED 12-29-87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank J. Mayo		22e. ADDRESS 16220 Frederick Rd. #213 Guthrieburg, MD 20877				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 31, 1987		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		
23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRINCE GEORGES MD		24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				
25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE				

MEDICAL CERTIFICATION

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BP

077136 JAN

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 3 6 1 2 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID ALAN CRAWFORD			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 30, 1987		2b. HOUR 1:15 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR SEPTEMBER 7, 1962		6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH, THE CLINICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electronic Tech.		12b. KIND OF BUSINESS OR INDUSTRY Electro-Plating	
13a. STATE TENNESSEE		13b. COUNTY Davidson		13c. CITY OR TOWN NASHVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN Wayne CRAWFORD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANN C. SELLERS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 1981-1985 244-25-5822	
17. INFORMANT ADDRESS MRS. NANCY CRAWFORD (WIFE) SAME AS DECEASED		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MELANOMA DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from NOVEMBER 13, 1987, to DECEMBER 30, 1987, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on DECEMBER 30, 1987, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.							
22b. SIGNATURE John P. Wei, M.D.				22c. DATE SIGNED 12/31/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) John P. Wei, M.D.	
22e. ADDRESS NATIONAL INSTITUTES OF HEALTH, 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 2, 1988		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Nashville Tennessee	
24. FUNERAL DIRECTOR Robert A. Pumphrey, Bethesda-Chevy Chase, Inc., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please send the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

017-30-200

OPTIONAL FORM NO. 10
MAY 1962 EDITION
GSA GEN. REG. NO. 27

10/10/62

10/10/62

074853 DEC

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 620 W. EDITION STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 38130

1a. SEX F		4. RACE W		5. DATE OF BIRTH June 1 1919 90 YRS		6. AGE (IN YEARS) LAST BIRTHDAY 90 YRS		7. DATE KNOWN OF DEATH EST. MATED Dec 6, 1987		2b. HOUR 12:45	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		12b. KIND OF BUSINESS OR INDUSTRY Vet. Admin.		2d. HOUR 12:45	
10. CITY OR TOWN OF DEATH Sil. Spg		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2300 East Gate Dr		12a. USUAL OCCUPATION (TYPE OF WORK) Retired U.S. Gov't		12b. KIND OF BUSINESS OR INDUSTRY Vet. Admin.		13a. STREET ADDRESS 3227 Ludham Drive 20855		13b. CITY OR TOWN Silver Spring	
14. FATHER'S NAME Thomas		15. MOTHER'S MAIDEN NAME Mason		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219 48 5075		17. INFORMANT 701 Warbler Lane Rockville, Md. Flora C. Rowse (daughter 20855)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		22d. LOCATION CITY OR TOWN COUNTY STATE					
23a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		23b. CITIZEN OF WHAT COUNTRY? U.S.A.		23c. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		23d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		23e. USUAL OCCUPATION (TYPE OF WORK) Retired U.S. Gov't		23f. KIND OF BUSINESS OR INDUSTRY Vet. Admin.	
24. FATHER'S NAME Thomas		25. MOTHER'S MAIDEN NAME Mason		26a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		26b. SOCIAL SECURITY NO. 219 48 5075		26c. INFORMANT 701 Warbler Lane Rockville, Md. Flora C. Rowse (daughter 20855)		26d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
27a. DATE OF OPERATION None		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		28. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		29a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		29d. LOCATION CITY OR TOWN COUNTY STATE		29e. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		29f. TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER DATE SIGNED Dec 6, 1987					
30a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		30b. CITIZEN OF WHAT COUNTRY? U.S.A.		30c. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		30d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		30e. USUAL OCCUPATION (TYPE OF WORK) Retired U.S. Gov't		30f. KIND OF BUSINESS OR INDUSTRY Vet. Admin.	
31. FATHER'S NAME Thomas		32. MOTHER'S MAIDEN NAME Mason		33a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		33b. SOCIAL SECURITY NO. 219 48 5075		33c. INFORMANT 701 Warbler Lane Rockville, Md. Flora C. Rowse (daughter 20855)		33d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
34a. DATE OF OPERATION None		34b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		35. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		36a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 36b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
36c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		36d. LOCATION CITY OR TOWN COUNTY STATE		36e. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		36f. TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER DATE SIGNED Dec 6, 1987					
37a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		37b. CITIZEN OF WHAT COUNTRY? U.S.A.		37c. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		37d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		37e. USUAL OCCUPATION (TYPE OF WORK) Retired U.S. Gov't		37f. KIND OF BUSINESS OR INDUSTRY Vet. Admin.	
38. FATHER'S NAME Thomas		39. MOTHER'S MAIDEN NAME Mason		40a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		40b. SOCIAL SECURITY NO. 219 48 5075		40c. INFORMANT 701 Warbler Lane Rockville, Md. Flora C. Rowse (daughter 20855)		40d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
41a. DATE OF OPERATION None		41b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		42. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		43a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 43b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					
43c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		43d. LOCATION CITY OR TOWN COUNTY STATE		43e. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		43f. TITLE (SPECIFY) M.D. Dep. MEDICAL EXAMINER DATE SIGNED Dec 6, 1987					
44a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		44b. CITIZEN OF WHAT COUNTRY? U.S.A.		44c. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		44d. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		44e. USUAL OCCUPATION (TYPE OF WORK) Retired U.S. Gov't		44f. KIND OF BUSINESS OR INDUSTRY Vet. Admin.	
45. FATHER'S NAME Thomas		46. MOTHER'S MAIDEN NAME Mason		47a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		47b. SOCIAL SECURITY NO. 219 48 5075		47c. INFORMANT 701 Warbler Lane Rockville, Md. Flora C. Rowse (daughter 20855)		47d. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
48a. DATE OF OPERATION None		48b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None		49. AUTOPSY							

07/04
25M

BP_____

DHMH - 17

(VR A15 ME (5))

DHMH - 17
 /R A15 ME (5)

054822 DEC 14 67



OFFICE
OF THE
DIRECTOR
OF THE
BUREAU OF
THE
ARMY
OF THE
UNITED STATES
OF AMERICA

074736 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the physician should not be omitted or blank.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 R.G. NO. 36131

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Domenic (none) Cristaudo			2a. DATE OF DEATH MONTH DAY YEAR Dec. 5, 1987		2b. HOUR 5:20 A		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 14, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
10. CITY OR TOWN OF DEATH Silver Springs		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Butler		12b. KIND OF BUSINESS OR INDUSTRY Blair House	
13a. STATE None		13b. CITY OR TOWN Wash. D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 5446 Broad Branch Rd. (20015)	
14. FATHER'S NAME FIRST MIDDLE LAST Antonio -- Cristaudo				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarita -- Bertiero			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 14 5934		17. INFORMANT Wife		ADDRESS Same as # 13 above.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>stroke - left hemisphere</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 d 6 d							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Congestive heart failure, Hypertension, old right hemisphere stroke</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 1, 1985</u> , to <u>Dec. 5, 1987</u> , that (I) (we) last saw the deceased alive on <u>Dec. 4, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>David V. Young, M.D.</u>				DEGREE M.D.		22c. DATE SIGNED Dec. 5, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David V. Young, M.D.				22e. ADDRESS 4530 Conn. Ave. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Dec. 7, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN STATE Silver Springs Md.	
24. FUNERAL DIRECTOR NAME ADDRESS <u>DeVol Funeral Home</u> 2222 Wisc. Ave. Washington D.C.				25a. DATE REC'D. BY REGISTRAR DEC 10 1987		25b. REGISTRAR'S SIGNATURE <u>Robert A. DeVol</u>	

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36132

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Phoebe E. Crocker			2a. DATE OF DEATH MONTH DAY YEAR 12-30-87		2b. HOUR 5³⁰ AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 13 96		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fed. Gov't.		12b. KIND OF BUSINESS OR INDUSTRY Clerk	
13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Hyatts.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Willis Crocker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Metcalf		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577 34 1288	
17a. PLACE OF DEATH 492 Lake Henry Circle		17b. ADDRESS Winter Haven, Florida		17c. NAME OF PERSON Chester M. Herbert (Nephew)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sepsis						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myelogenous Leukemia						3 Months	
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 8, 1987 to Dec 30, 1987 , that (I) (we) last saw the deceased alive on Dec 30, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE Attending Physician		22c. DATE SIGNED 30 Dec 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibovitch MD		22e. ADDRESS 11120 N. Hwy 9, N. 20804					
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 1/2/88		23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

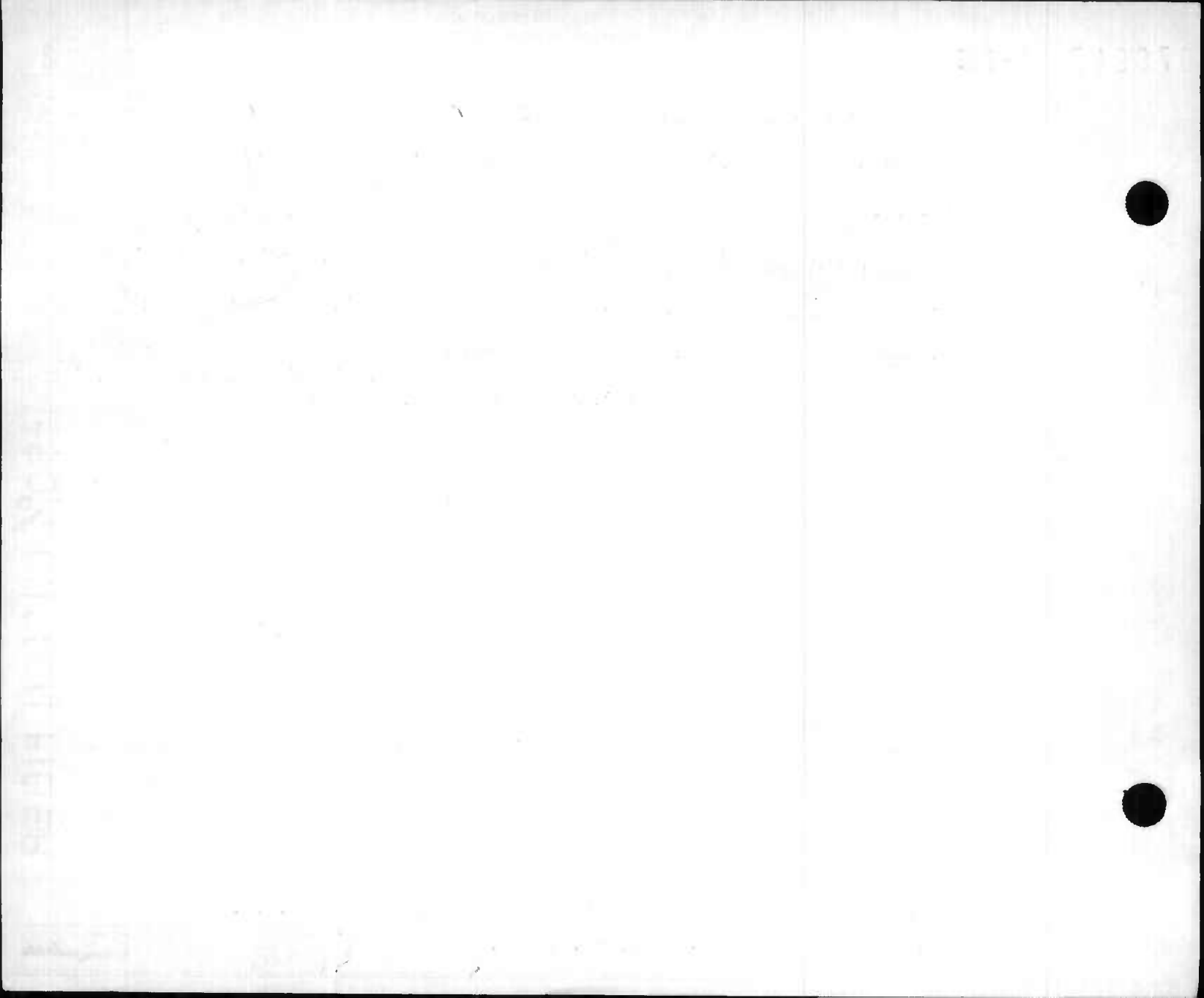
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 1/81
(VRA 15, 4)



075233 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36133

DECEASED NAME (TYPE OR PRINT) WILBUR E CUNNINGHAM			2a. DATE OF DEATH MONTH DAY YEAR 12-11-87		2b. HOUR 11:20 AM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 14, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co., MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Paint Store
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Floyd Cunningham		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Alexander		13e. STREET ADDRESS 20817 7420 Westlake Terrace #102	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1944	17. INFORMANT Rose L. Cunningham		ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUDDEN CARDIAC DEATH</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>VENTRICULAR FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CORONARY ARTERY DISEASE</u>					APPROXIMATE INTER- BETWEEN ONSET AND D.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>12/11</u> 19 <u>87</u> , to <u>12/11</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/11</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Mark F. Weinstein MD		DEGREE		22c. DATE SIGNED 12/11/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark F. Weinstein		22e. ADDRESS 1125 Rockville Pike Rockville			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 15, 1987	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Bethesda-Chevy Chase, Inc. Ave. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 15 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Baker	

BP

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DEC 18 1987



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of Pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

Film G635 item 17, 1/26/88 rja

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36135

1. DECEASED NAME (TYPE OR PRINT) SARA K. DARNER				2a. DATE OF DEATH MONTH 12 DAY 12 YEAR 87		2b. HOUR 2:20 AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH Mar. DAY 31 YEAR 1900		6. AGE (IN YEARS LAST BIRTHDAY) 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Beth.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE DC				13b. COUNTY W.A.		13c. CITY OR TOWN Wash., DC	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS / ZIP CODE 2712 WI Ave. NW			
14. FATHER'S NAME FIRST Robert MIDDLE Rhea LAST Kane				15. MOTHER'S MAIDEN NAME FIRST Josephine MIDDLE Edmonds LAST Edmonds			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-50-4855		17. INFORMANT Sally D. Nicholas		ADDRESS 7721 McLean, VA 5721 Tremayne Pl. 22102	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 2 19 87 , to Dec. 12 19 87 , that (I) (we) lost saw the deceased alive on Dec. 2 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H.A. Grennan M.D.						22c. DATE SIGNED Dec. 12, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.A. Grennan, M.D.				22e. ADDRESS 1145 - 19th St. NW Wash., DC 20036			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/16/87		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, VA	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR DEC 16 1987			
				25b. REGISTRAR'S SIGNATURE <i>Julia F. ...</i>			

BP
DHMH - 16 60M 7/84
(VRA 15, 4)

077843 JAN 12 1988

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36136

1- STATE REGISTRAR 1250		FOR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Edythe Quinn Davis							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR
F	W	April 28 1908	87 YRS.			Jan 2 1988	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Philadelphia Pa.		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Sol. Spg.		1305 Noyes Dr.		Home Maker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS	
Md.		Montg.		Sol. Spg.		1305 Noyes Dr. 910	
14. FATHER'S NAME (FIRST, MIDDLE, LAST)		15. MOTHER'S MAIDEN NAME (FIRST, MIDDLE, LAST)		16. SOCIAL SECURITY NO.		17. INFORMANT (NAME AND ADDRESS)	
John Nelson Quinn		Mildred Reitel		216-46-4108		The Rev. Robert N. Davis 1814 Burlingame Rd. Catonsville Md.	
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		18b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		216-46-4108		The Rev. Robert N. Davis		1814 Burlingame Rd. Catonsville Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
<u>None</u>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION (STREET, CITY OR TOWN, COUNTY, STATE)			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
<u>John S. Rogers</u>		M.D. Dep.				Jan 3 1988	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
John S. Rogers		1919 Seminary Rd., S.S., Md.					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)	
Cremation		Jan 4 - 1988		Parklawn Cemetery.		Rockville Montg. Co.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Arthur Waters		JAN 11 1988		[Signature]			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, LONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25M

BP _____
DHMH - 17
(VR A15 ME (5))

057843 15 00

Philadelphia Pa

MSA

x

State Museum

Hotel
1717 Locust St
Philadelphia Pa



Philadelphia - 1912

Philadelphia

076316 DEC 28 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 3 6 1 3 7

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

MARENA

DAVIS

2a. DATE OF DEATH MONTH DAY YEAR
12-22-87
2b. HOUR
8:30 P.M.

3. SEX

FEMALE

4. RACE

White

5. DATE OF BIRTH

MONTH DAY YEAR
10 16 90

6. AGE (IN YEARS LAST BIRTHDAY)

97

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS

HOURS MIN.

7a. BIRTHPLACE
(STATE OR FOREIGN
COUNTRY)

N.C.

7b. CITIZEN OF WHAT COUNTRY?

U.S.

8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY COUNTY MD.

10. CITY OR TOWN OF DEATH

SILVER SPRING

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Colonial Villa N. H.

12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)

Colorist

12b. KIND OF BUSINESS OR
INDUSTRY

Artist

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

MD

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

14605 CARROLLTON Rd.

14. FATHER'S NAME

GUSTOVIS

MIDDLE

LAST

DIGOTT

15. MOTHER'S MAIDEN NAME

MARTHA

MIDDLE

PAKE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO.

241 44 6466

17. INFORMANT

ADDRESS

Martha Apel (Daughter) Same as 13E

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Respiratory arrest

DUE TO, OR AS A CONSEQUENCE OF

(b)

Sepsis and gangrene

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(c)

Severe occlusive arterial dz

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Stroke

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

CITY OR TOWN

COUNTY

STATE

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK22a. I certify that (I) (this hospital) attended the deceased from
saw the deceased alive on 12/22/1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (If we (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

CHARLES BENNER MD

22e. ADDRESS

ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

12-22-87

11161 NEW HAMPSHIRE
SILVER SPRING, MD 2090423a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/30/87

23c. NAME OF CEMETERY OR CREMATORY

Straits Cemetery

23d. LOCATION

Straits North Carolina

24. FUNERAL DIRECTOR
Name AddressHines/Rinaldi 11800 New Hamp. Ave. S.S.
Md.

25a. DATE REC'D. BY REGISTRAR

DEC 28 1987

25b. REGISTRAR'S SIGNATURE

Julia Sandom Rinaldi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

BP

070310 DEC 2003

4

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Project" and "Phase" are faintly visible.]

[Faint handwritten notes or a small sketch in the bottom left corner.]

074673 DEC 10 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36138
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST McDoanald Lee Davls			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 2 1987		2b. HOUR 9 A.M.	
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 30 00		
6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		
12b. KIND OF BUSINESS OR INDUSTRY Harvey Dairy		13a. STATE Maryland		13b. COUNTY Prince George's W. Hyattsville		
13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 5900 33rd Avenue 20782		
14. FATHER'S NAME FIRST MIDDLE LAST Elijah Davis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olivia R. Asbury				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 213-01-5315		17. INFORMANT Erva L. Early (Step Daughter) W. Hyattsville, Maryland, 20782		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF: (c) CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24 HOURS 1 YEAR 2 YEARS						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: None						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JANUARY 1 1987 to DEC 2 1987 , that (I) (we) last saw the deceased alive on OCTOBER 28 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Samuel J. N. Sugar MD		DEGREE MD		22c. DATE SIGNED 12/3/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SAMUEL J. N. SUGAR MD.		22e. ADDRESS 4637 EASTERN AVENUE MT. RAINIER, MD 20712				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/04/87		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland		24. DATE REC'D. BY REGISTRAR DEC 09 1987				
25. REGISTRAR'S SIGNATURE Julia Davidson Fordell						

BP

98 01 320 2 5 3 4 5 0

989 0030

076630 DEC 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		3. SEX		4. RACE		5. DATE OF BIRTH	
1. DECEASED NAME (TYPE OR PRINT)		2b. MONTH DAY YEAR		FEMALE		CAUCASIAN		APRIL 4 1896	
MARY NAIL DAWSON		12 25 87							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. AGE (IN YEARS LAST BIRTHDAY)		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
PENNSYLVANIA		USA		91 YRS		MONTGOMERY MD.		TAKOMA PARK	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS / ZIP CODE		13b. COUNTY	
WASHINGTON ADVENTIST HOSPITAL		HOUSEWIFE				10521 CARNATION COURT 20783		PR GEORGES	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
WILLIAM NAIL		ELLEN E. FLECK		NO		577-62-2867		ABIGAIL H. SEEHOLD/DAUGHTER/SAME AS 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SUSPECTED MYOCARDIAL INFARCTION</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>PULMONARY FIBROSIS, ADVANCED</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN COUNTY STATE)					
22a. I certify that (I) (this hospital) attended the deceased from <u>NOV 01</u> 19 <u>82</u> to <u>PRESENT</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>NOV 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/25/87</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ESMACIADO</u>		22e. ADDRESS <u>321 PARKLE GEORGE STREET</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		23b. DATE <u>DEC 27, 1987</u>		23c. NAME OF CEMETERY OR CREMATORY <u>METROPOLITAN CREMATORY ALEXANDRIA</u>		23d. LOCATION (CITY OR TOWN COUNTY STATE) <u>VIRGINIA</u>			
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS, JR.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		24c. DATE OF REGISTRATION <u>DEC 30 1987</u>					
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901									

1913

RECEIVED JANUARY 10 1913

RECEIVED JANUARY 10 1913

RECEIVED JANUARY 10 1913

RECEIVED JANUARY 10 1913

RECEIVED JANUARY 10 1913

075298 DEC 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36140

1. DECEASED NAME FIRST MIDDLE LAST Towles L Dawson		2a. DATE OF DEATH MONTH DAY YEAR 12 9 87		2b. HOUR 8:35AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 18 18	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Waxachachie, TX		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 69 YRS	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
13a. STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Temple Hills	
14. FATHER'S NAME FIRST MIDDLE LAST S. E. Dawson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kittie Mae Williams		12a. USUAL OCCUPATION (TYPE OF WORK OR WORKING (IFE)) Attorney Retired	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII		16b. SOCIAL SECURITY NO. 459-12-6627		17. INFORMANT ADDRESS Medical Record	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9 Dec 87 to 9 Dec 87, that (I) (we) last saw the deceased alive on 9 Dec 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated.							
22b. SIGNATURE THOMAS A. BENSHAW		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/9/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 7525 Greenway Ctr Dr. Bethesda MD 20870					

23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 12/12/87		23c. NAME OF CEMETERY OR CREMATORY Riverdale Bapt. Ch. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Upper Marlboro P.G. Md	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home, Inc 3 Old Alexander Ferry Rd Clinton, Md 20735				25a. DATE REC'D. BY REGISTRAR DEC 16 1987		25b. REGISTRAR'S SIGNATURE green	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36141

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Evelyn M. Dean								Dec 19 1987		10		24		AM							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
F		W		Dec 15 1927		60 YRS.						Dec 17 1987		19		PM		24		AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
PENNSYLVANIA		USA										Montgomery MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY															
S. L. Spg.		Holy Cross Hosp		MUSIC TEACHER		D.C. PUBLIC SCHOOLS															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
MD		Mont-		S. L. Spg		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2911 Hewitt Ave												20906	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST									
JAMES ALLEN MASON						HAZEL COBB															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
NO		567-22-2108		SON		2030 EVARTS ST.															
				GREGORY DEAN		WASHINGTON, DC 20018															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF															
				Acute Myocardial Dis																	
				(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
None																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																	
		P.M.		19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion													
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED													
EXAMINER'S NAME		JOHN S. ROGERS		SEMINARY ROAD SILVER SPRING, MD																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE									
CREMATION		DEC 20, 1987		METROPOLITAN CREMATORY		ALEXANDRIA															
24. FUNERAL DIRECTOR		NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
		FRANCIS J. COLLINS, JR.		500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		DEC 24 1987															

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36142	
1- FOR STATE REGISTRAR		DECEASED NAME (Type or Print) Richard E. Dean		LAST Dean		2a. DATE KNOWN OF DEATH ESTIMATED Dec. 26, 1987		MONTH DAY YEAR		2b. HOUR MIN.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Jan 7, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR CITY OR TOWN) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Postal Service		13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS Batson 20868		13c. CITY OR TOWN Spencerville		13d. STATE Md	
14. FATHER'S NAME FIRST MIDDLE LAST Alfred R. Dean		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Trammell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Korean 217-28-1914		17. INFORMANT ADDRESS Frances I. Dean - wife - (same as 13c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None											
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John S. Rogers		TITLE (SPECIFY) Dep.		M.D. Dep.				MEDICAL EXAMINER		DATE SIGNED Dec 26 1987	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME		ADDRESS 1919 Seminary Rd., S.S. Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-1987		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Montgomery Md.					
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Sil. Spr. Md.		25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE Julia Dodson-Randall					

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DHMH - 17
(VR A15 ME (5))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36143

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KENNETH DELIN		2a. DATE OF DEATH MONTH DAY YEAR 12/30/87		2b. HOUR 0210M	
3. SEX M Male		4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR March 2, 1896	
6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.		10. CITY OR TOWN OF DEATH SILVER SPRING	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 8505 Springvale Terr. / 20910			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 085-09-6783		17. INFORMANT ADDRESS Janet Westberg (Neice) 11115 Jolly Way Kensington, Md. 20895	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) Sepsis Hypotension DUE TO, OR AS A CONSEQUENCE OF (c) Urinary tract infection					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Gi Bleed, Congestive Heart Failure, Arteriosclerosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 87 to Dec 30 19 87 , that (I) (we) lost saw the deceased alive on Dec 29 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Hugo G. Graziani		22c. DATE SIGNED 12-30-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUGO G. GRAZIANI	
22e. ADDRESS 717 Pennington Drive Silver Spring, MD 20910		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			
23b. DATE Jan/2/88		23c. NAME OF CEMETERY OR CREMATORY Chambers Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Riverdale, P.G. Co., Maryland	
24. FUNERAL DIRECTOR NAME Chambers Funeral Home		ADDRESS Silver Spring, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 11 1988	

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Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Some visible words include "United", "To", "From", "Date", "Time", "Place", "Subject", "Remarks", "Signature", "Date", "Time", "Place", "Subject", "Remarks", "Signature".

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#7a, per F.H. 12/23/87 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36144

1. DECEASED NAME (TYPE OR PRINT) Joseph B. Dempsey, JR			2a. DATE OF DEATH MONTH DAY YEAR DEC 10, 1987		2b. HOUR 4:50 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR JUNE 6, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FED. GOVT (RET)		12b. KIND OF BUSINESS OR INDUSTRY NAVY DEPT.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION) 13a. STATE MD	13b. COUNTY PR. GEO	13c. CITY OR TOWN ADELPHI	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1836 METZEROTT ROAD 20783	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH B. DEMPSEY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY COFFEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 401-20-7551		17. INFORMANT RUTH D. WARDEN ADDRESS ROANOKE VA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio pulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>End Stage Hepatitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Renal Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <u>12/9/87</u> to <u>12/10/87</u> that (I) (we) last saw the deceased alive on <u>12/9/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22a. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED 12/10/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VIVER C VAID M.D.		22e. ADDRESS 3311 Talado Terrace Hyattsville Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE DEC. 12, 1987	23c. NAME OF CEMETERY OR CREMATORY DEMPSEY CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WARFIELD KENTUCKY
24. FUNERAL DIRECTOR NAME Takoma Funeral Home-Washington, D.C.		25a. DATE REC'D. BY REGISTRAR DEC 11 1987		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, please see any injury or other traumatic event. The medical examiner must be notified and a report filed.

BP

DHMH - 16 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36145

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert S. Dennis		2a. DATE OF DEATH MONTH DAY YEAR 12-01-87		2b. HOUR MIN. 4:15 P	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 13 20	
6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66		7. IF UNDER 1 YEAR MONTHS DAYS 66		8. IF UNDER 24 HRS. HOURS MIN. 66	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn. A. Pennsylvania		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. CITY OR TOWN OF DEATH Gloucester Springs		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		14. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) American Instrument Co.-Sales		16. KIND OF BUSINESS OR INDUSTRY		17. STREET ADDRESS / ZIP CODE 10136 Riggs Road 20783	
18a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY PG		13c. CITY OR TOWN Adelphi	
14. FATHER'S NAME FIRST MIDDLE LAST Robert D. Dennis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Neiper		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII	
17. SOCIAL SECURITY NO. 159 16 7299		18. INFORMANT Anne Dennis (Wife) Same as 13E		19. ADDRESS	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Ischemia / PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 24 hrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21g. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/30 , 19 87 , to 12/1 , 19 87 , that (I) (we) lost saw the deceased alive on 12/1 , 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry H. Bisk		DEGREE MD		22c. DATE SIGNED 12/1/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PENNY C BISK		22e. ADDRESS 103136 RIGGS AVE		22f. CITY OR TOWN Mont. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/4/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. FUNERAL DIRECTOR Hines, Rinaldi		23e. ADDRESS 11800 New Hamp Ave. S.S. Md.		23f. DATE REC'D. BY REGISTRAR DEC 03 1987	
23g. REGISTRAR'S SIGNATURE Julia		23h. REGISTRAR'S SIGNATURE Julia		23i. REGISTRAR'S SIGNATURE Julia	

03403-5-20

1

4 4 2 6 DEC -8 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 7 REG. NO. 3 6 1 4 6

1. DECEASED NAME (TYPE OR PRINT) ELSIE V. DERFINGER			2a. DATE OF DEATH MONTH 12 DAY 2 YEAR 87		2b. HOUR 12:30 M
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 10 DAY 14 YEAR 13		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY Bakery
13a. STATE Maryland		13b. COUNTY P. Georges	13c. CITY OR TOWN Morningside	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	
14. FATHER'S NAME FIRST Edward MIDDLE LAST Smith		15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Frances LAST Aleshire			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 228 28 6098		17. INFORMANT ADDRESS 6704 Suitland Road Morningside, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Conditions, if any, which gave rise to immediate cause (d), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: PERSES					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/30 19 87 , to DEC 2 19 87 , and that (I) (we) last saw the deceased alive on 11/30 19 87 , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Terence Rutele MD		22c. DATE SIGNED December 3, 1987		22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERENCE RUTELE MD	
22e. ADDRESS 7501 SURREYS RD Centon MD 20735		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 12/5/1987		23c. NAME OF CEMETERY OR CREMATORY Rileyville Cemetery		23d. LOCATION CITY OR TOWN Rileyville COUNTY Page Va. STATE 	
24. FUNERAL DIRECTOR NAME Bradley Funeral Home		ADDRESS Luray, Virginia		25a. DATE REC'D. BY REGISTRAR DEC -7 1987	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

State of Tennessee
County of _____

I, _____
do hereby certify that _____

_____ is the _____
of the _____

_____ of the _____

_____ of the _____

_____ of the _____

_____ of the _____

075370 DEC 7 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
MARCEL R. Desgalier					12 - 9 - 87					4:15 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.
MALE		CAUCASIAN		JUNE 29 1892			95				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
SWITZERLAND		USA					MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
WHEATON		WHEATON MANOR CARE					MINISTER				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
MARYLAND		MONTGOMERY		SILVER SPRING				13116 EWOOD LANE 20906			
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
FREDERICK OSCAR DESGALIER					ELISE GURTNER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO					152-28-5121		HELEN W. DESGALIER/WIFE/SAME AS 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC RENAL FAILURE</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONGESTIVE HEART FAILURE - HYPERTENSION</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>ONE WEEK</u> <u>5 years</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>80</u> to <u>DECEMBER</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>DEC 4</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>R. MATHEUS</u> MD					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>12/9/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>R. MATHEUS</u>					22e. ADDRESS <u>13018 GEORGIA AVENUE, WHEATON, MD 20906</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		DEC. 16, 1987		HILLCREST CEMETERY		LEESBURG LAKE FLORIDA					
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Julia Davis</u>			
						DEC 16 1987					

076377 DEC 28 1987

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36148
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Jessica Jean Devairakkam			2a. DATE OF DEATH MONTH DAY YEAR 12-19-87			2b. HOUR 6³⁵ A.M.				
3. SEX Female		4. RACE Asian		5. DATE OF BIRTH MONTH DAY YEAR 12-12-87		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 7		IF UNDER 1 YEAR MONTHS DAYS 7		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY N/A			
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST James Solomon Devairakkam			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kalyanie F. Somasunderam			13e. STREET ADDRESS / ZIP CODE 19532 Laguna Drive 20879				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS James S. Devairakkam (father) same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory insufficiency (failure) DUE TO, OR AS A CONSEQUENCE OF (b) Camptomic dysplasia syndrome DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>at Children's Hospital</i>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-12 , 19 87 , to 12-19 , 19 87 , that (I) (we) last saw the deceased alive on 12-19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
22b. SIGNATURE Maureen Miller					DEGREE MD		22c. DATE SIGNED 12-19-87		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Maureen Kay Miller					22e. ADDRESS Dept of Neonatology Holy Cross Hospital 1500 Forest Glen Rd, Silver Spring, Md					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY OR TOWN Silver Spring, Maryland		
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852					25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Devairakkam</i>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



2020-10-10
10:00 AM
10:00 AM
10:00 AM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. **3** **0** **1** **4** **9**

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
 THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS
 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,
 BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		2a. DATE KNOWN OF DEATH		RECEIVED	MONTH DAY YEAR		2b. HOUR
Thomas S. Devlin								Dec. 25 1987				509 PM
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR	7d. HOUR
Male	Caucasian	March 18, 1935		52 YRS.					Dec. 25 1987			PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		United States		WIDOWED		DIVORCED		Montgomery MD				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring		Holy Cross Hosp				Owner		Tree Ser.Co.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		20902		
Md		Mont.		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2506 Lindell St.				
14. FATHER'S NAME		FIRST	MIDDLE	LAST		15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
Thomas Edward Devlin						Veronica Sawyer						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife) ADDRESS								
No		214 32 9717		Grace Jewell Devlin Same as line #13.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Myocardial Dist</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I												
<u>None</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
<u>None</u>								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED				
<u>John S. Rogers</u>		M.D.		Gepv				Dec 26 / 1987				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Rd.		Silver Spring, Md.		20910				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		December 30, 1987		Gate of Heaven Cemetery		Silver Spring		Maryland				
24 FUNERAL DIRECTOR NAME		24b. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE								
Robert A. Humphrey Funeral Home/ Rockville Inc.		DEC 29 1987		F. K. ...								
300 West Montgomery Ave. Rockville, Maryland												

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077065 JAN - 5 1988

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36150

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEATRICE VIRGINIA DEY			2a. DATE OF DEATH MONTH DAY YEAR 12 31 88		2b. HOUR 2329 PM		
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 9 21 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MINT GONERY MD.	
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP. INC.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home maker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY PR. GEO.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT S JONES		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-03-9626	
17. INFORMANT MARTHA CREECH		ADDRESS 5708 SARGENT RD HYATT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE Pulmonary embolism. DUE TO, OR AS A CONSEQUENCE OF (c) POSSIBLE acute myocardial infarction.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: TEMPORAL ARTERITIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 12/31/87 19 87 , to 12/31 19 87 , that (I) (we) last saw the deceased alive on 12/31 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE TIP. WOODWARD		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/1/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIP. WOODWARD, M.D.		22e. ADDRESS 5530 WISCONSIN AVE. CHEVY CHASE 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Jan 5, 1988		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Durham MD	
24. FUNERAL DIRECTOR Elmer Walters		ADDRESS 254 Carroll St. N. W. D. CHAN 4		DATE REC'D. BY REGISTRAR 1/5/88		REGISTRAR'S SIGNATURE Lia F...	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201
CLEARED WITH DR. ROGERS, DEP. MED. EXAM.

BP

DHMH - 16 50M 1/BI
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial or transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

077095 JAN

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6151

1- STATE REGISTRAR		FOR STATE REGISTRAR		1- DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
David		Diamond		12-27 19 87		M		12-27 19 87		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. HOUR				
MALE	CAUCASIAN	3 15 42	45 YRS.	MONTHS	DAYS	12-28 19 87	3:45				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
WASHINGTON, D.C.		U.S.A.				Montgomery County, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		4853 Cordell Ave., Apt. 1021		BUSINESS EXEC.		REFUSE IND.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		MONTGOMERY		BETHESDA		YES <input type="checkbox"/> NO <input type="checkbox"/>		4853 CORDELL AVE (20814)			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
AARON		CECELIA		NO		220-38-2504		FATHER		LAUDERHILL, FLA. 33313	
		DIAMOND						AARON DIAMOND: 4740 N.W. 21st ST. #4-P			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Hypertensive Arteriosclerotic Cardiovascular											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF					
				(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
Seizure Disorder											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		12-28-87					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
BURIAL		12/30/87		MT. LEBANON CEMETERY		ADELPHI				MARYLAND	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
DANZANSKY-GOLDBERG MEMORIAL CHAPELS		JAN 4 1988									
1170 ROCKVILLE PIKE; ROCKVILLE, MD 20852											

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36152

1. FOR
STATE
REGISTRARDECEASED NAME
(TYPE OR PRINT)

FIRST MIDDLE LAST

SONIA J.

LAST

DIAZ

20. DATE OF DEATH MONTH DAY YEAR 12 25 87 21. HOUR 11 45 A M

3. SEX

Female

4. RACE

Caucasian

5. DATE OF BIRTH

MONTH DAY YEAR 1 18 49

6. AGE (IN YEARS LAST BIRTHDAY)

38 YRS

IF UNDER 1 YEAR IF UNDER 24 HRS

MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Guatemala

7b. CITIZEN OF WHAT COUNTRY?

Guatemala

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Housewife

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE md

13b. COUNTY Montgomery

13c. CITY OR TOWN Silver Spring

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS

1936 Rosemary Hills #2 20910

14. FATHER'S NAME

FIRST MIDDLE LAST Antonio Lopez

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST Zoila Escobar

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

No

16b. SOCIAL SECURITY NO.

219-08-7474

17. INFORMANT

Edgar Rene Diaz Husband Same as 13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Hepatic encephalopathy

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

1 wk.

DUE TO, OR AS A CONSEQUENCE OF—

(b)

Cirrhosis

2 mo.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 110.

Coagulation defect

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 9 19 87, to 12/25 19 87, that (we) last saw the deceased alive on 12/24 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Peter Sherer

DEGREE

MD

ATTENDING PHYSICIAN

MEDICAL DIRECTOR ☒STAFF PHYSICIAN ☐

22c. DATE SIGNED

12/25/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Peter Sherer MD

22e. ADDRESS

3947 Ferrara Dr. Wheaton, MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

Dec. 29, 1987

23c. NAME OF CEMETERY OR CREMATORY

Gate of Heaven

23d. LOCATION CITY OR TOWN COUNTY STATE

Silver Spring Montgomery Md.

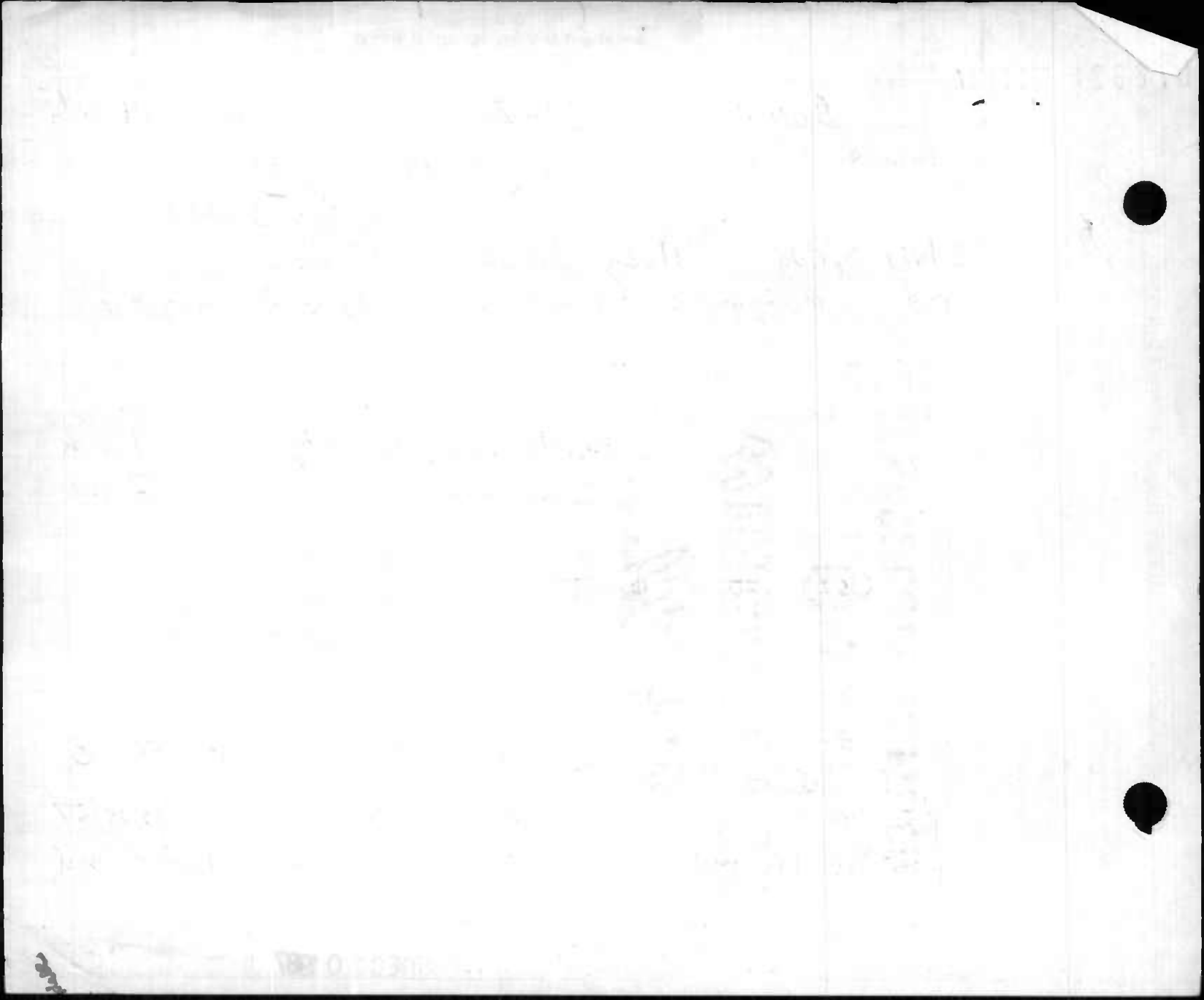
24. FUNERAL DIRECTOR NAME

Francis J. Collins, Jr.

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

500 University Blvd., W. Silver Spring, MD. 20901 DEC 30 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36153

1 - FOR
STATE
REGISTRAR

11 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Delore Dobretz		2a DATE OF DEATH MONTH DAY YEAR 12 17 87		2b HOUR 19:47M	
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JAN. 22, 1915	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) UNKNOWN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 82	
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SHADY GROVE ADVENTIST HOSPT.		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b KIND OF BUSINESS OR INDUSTRY AT HOME		13a STREET ADDRESS / ZIP CODE #501 6817 GEORGIA AVE N.W. 20011	
13a STATE D.C.		13b COUNTY NONE		13c CITY OR TOWN WASHINGTON	
14 FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b SOCIAL SECURITY NO. 505-20-0463		17. INFORMANT ADDRESS WILLIAM F. REED 1725 K. ST. N.W., WASH. DC.		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Severe Reptile DUE TO, OR AS A CONSEQUENCE OF (c)	

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
22a. I certify that (I) (this hospital) attended the deceased from Nov 24, 1987 to 12-17, 1987 , that (I) (we) lost saw the deceased alive on 12-3, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Hien-D. Khruang				DEGREE MD		22c. DATE SIGNED 12/17/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HIRU-D. KHTANEY				22e. ADDRESS 20428 Germantown Rd, Germantown, Md.			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 22, 1987		23c. NAME OF CEMETERY OR CREMATORY CHAMBERS CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE RIVERDALE, P.G.C. Md.	
24 FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.				ADDRESS RIVERDALE, Md/20737		25. DATE REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DEC 28 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, illegible handwriting visible through the paper]

050 53 030

075791 DEC 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/interment permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36155

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2b. DATE OF DEATH		MONTH DAY YEAR		2c. HOUR	
		ROSCOE		DORSEY		Dec. 11		1987		5:26 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		BLACK		5-24-1910		77		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MD		U.S.A.				MONTGOMERY				MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		Water-Rooter							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Md. Montg. Silver Spring				13313 Octagon Lane				120904			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, HE DIED UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
William H. Dorsey		Sally Simms		Yes		213-16-2277		Diane McElroth (daughter)		Same AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)		19. PART I. DEATH CAUSED BY:		20. IMMEDIATE CAUSE (a)		20. IMMEDIATE CAUSE (b)		20. IMMEDIATE CAUSE (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				CARDIAC ARREST ASSOC WITH HYPERKALEMIA		ACUTE RENAL FAILURE		BILATERAL URETERAL OBSTRUCTION - ADENOCARCINOMA		3-5 min 2-3 DAYS	
21. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.		22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		23. MULTIPLE PULMONARY EMBOLI - PROSTATIC METASTATIC BONE							
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, BOTH MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		33. LOCATION (STREET CITY OR TOWN COUNTY STATE)							
34. I certify that (a) (this hospital) attended the deceased from above, (b) (we) (did) (did not) view the body after death.		35. DEC 11 1987		36. 85 to Dec 11, 1987		37. that (b) (we) lost					
38. SIGNATURE		39. DEGREE		40. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		41. DATE SIGNED					
LAURENCE MARCOS, MD		MD		10313 GEORGE AVE		12/11/87					
42. BURIAL, CREMATION, REMOVAL (SPECIFY)		43. DATE		44. NAME OF CEMETERY OR CREMATORY		45. LOCATION (CITY OR TOWN COUNTY STATE)					
Burial		12-17-87		Md. Nat'l Mem. Park		Laurel, Pr. Geo. MD					
46. FUNERAL DIRECTOR NAME		47. ADDRESS		48. DATE REC'D. BY REGISTRAR		49. REGISTRAR'S SIGNATURE					
George R. Snowden		Rockville, MD 20850		DEC 15 1987		Julia [Signature]					

BP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36156

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NANCY S. DONALDSON			2a. DATE OF DEATH MONTH DAY YEAR 12 16 87		2b. HOUR 0812 M	
3. SEX F		4. RACE C		5. DATE OF BIRTH MONTH DAY YEAR 04 27 18		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Wheaton		
14. FATHER'S NAME FIRST MIDDLE LAST IRA SHANTZ		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GLADYS BERRY		17b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-12-7564		17. INFORMANT ADDRESS SON 4137 RED BANDANA ROBERT S. DONALDSON/WAY ELICOTT CITY, MD 21043		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours/day 23 days years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) chronic renal insufficiency, respiratory failure - ventilator dependent, COPD						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		70a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
71a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		71b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		71c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
71d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		71e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		71f. LOCATION STREET CITY OR TOWN COUNTY STATE		
72. I certify that (I) (the hospital) attended the deceased from Nov 23 19 87, to Dec 16 19 87, that (he) (we) lost saw the deceased alive on Dec 15 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
72b. SIGNATURE Roger F. Leonard		DEGREE MD		72c. DATE SIGNED 12/16/87		
72d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger F. Leonard		72e. ADDRESS 10401 Old Georgetown Rd, Bethesda MD 20814				
73a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		73b. DATE DEC 18, 1987		73c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		
74. FUNERAL DIRECTOR FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		73d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGE MD		75. DATE REC'D. BY REGISTRAR DEC 21 1987		
		75b. REGISTRAR'S SIGNATURE Julia Dwyer-Randall				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36157

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William G. Dorsey			2a. DATE OF DEATH MONTH DAY YEAR Dec 10, 87		2b. HOUR 4:15 PM		
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Dec 15, 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 20533 Zion Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cement Finisher		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Richard Dorsey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estella Brown		16. SOCIAL SECURITY NO. 579-05-6624A			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-05-6624A		17. INFORMANT ADDRESS Mrs Evangeline Dorsey Gaith. Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of lung with CNS mets</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 7 mo. 8 mo.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Obstructive Lung Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 19 <u>85</u> , to <u>Dec. 10</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>Sept. 23</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Frank J. Mayo		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRANK J. MAYO		22e. ADDRESS 16220 Frederick Rd. #213 Gaithersburg, MD. 20877					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-15-87		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg. MD	
24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850				25a. DATE REC'D. BY REGISTRAR DEC 15 1987			
				25b. REGISTRAR'S SIGNATURE Julia Anderson			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="display: flex; justify-content: space-between;"> <div> FOR STATE REGISTRAR CARL E. DOVE </div> <div> REG. NO. 36158 </div> </div>									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL E DOVE					2a. DATE OF DEATH MONTH DAY YEAR 12-6-87		2b. HOUR 14:28 M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR AUGUST 20, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY HOSPITAL			
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 109 WOODLAND ROAD 20877	
14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN - DOVE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH - LOWRY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT MABEL E. DOVE		ADDRESS SAME AS # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Obstructive Pul. Disease								DUE TO, OR AS A CONSEQUENCE OF yes	
(c) anti-typus def								DUE TO, OR AS A CONSEQUENCE OF yes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: pneumonia, malnutrition, UTI, pneumonia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 85 12-6 87					
22a. I certify that (1) (the hospital) attended the deceased from 12-4-87 to 12-6-87 , that (1) (was) lost saw the deceased alive on 12-4-87 , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did not) view the body after death.									
22b. SIGNATURE John S. Saia				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/7/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J.S. SAIA MD				22e. ADDRESS 809 Viers Mill Rd Rock MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 9, 1987		23c. NAME OF CEMETERY OR CREMATORY ST. LUKE'S LUTHERAN		23d. LOCATION CITY OR TOWN COUNTY STATE REDLAND MONT. MD.			
24. FUNERAL DIRECTOR NAME ADDRESS MURIEL H. BARBER LAYTONSVILLE, MD. 20879				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 09 1987 <i>Julia Davidson Anderson</i>					

MEDICAL CERTIFICATION

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DEC 10 2021

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 30159

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST COURTNEY ROLAND Doyle		2a. DATE OF DEATH MONTH DAY YEAR 12 31 87		2b. HOUR 9:38 P.M.	
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 4 48		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Trinidad, W.I.	7b. CITIZEN OF WHAT COUNTRY? Trinidad	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AUTO MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED
13a. STATE TRINIDAD, W.I.		13b. COUNTY	13c. CITY OR TOWN AROUCA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY DOYLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ENID MCDONALD		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. N/A		17. INFORMANT SISTER-IN-LAW JANET DOYLE		ADDRESS 2212 HANNON ST. HYATTSVILLE, MD 20787	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACEREBRAL HAEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Infarcts</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CARDIOMYOPATHY</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>MITRAL STENOSIS + Incompetence + Atrial fibrillation</u>					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> N/A		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-26</u> , 19 <u>87</u> , to <u>12/31</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) did not view the body after death.					
22b. SIGNATURE <i>[Signature]</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. JOSHI M.D.		22e. ADDRESS WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Md. 20912			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE JAN 7, 1988		23c. NAME OF CEMETERY OR CREMATORY AROUCA ANGLECAN CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE TRINIDAD ST. GEORGES W.I.		24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			
25a. DATE REC'D. BY REGISTRAR JAN 5 - 1988		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36160
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		HRS. MIN.	
FIRST MIDDLE LAST		12 6 87		11 40 M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
FEMALE	WHITE	MONTH DAY YEAR	76	MONTHS DAYS	HOURS MIN.
				11 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	USA		Montgomery MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore	Suburban Dean	Housewife	Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		
Maryland	Montgomery	BOTOMAC	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	11706 Coldstream Drive			
Israel	Miller	Annie			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO	N/A	Elizabeth Baer			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a).		ADDRESS			
Renal failure		206 Coldstream Dr. Botomac, Md			
DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		4 hr.			
(b) Diabetes Mellitus		15 yrs.			
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
Essential hypertension; urinary tract infection					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
12/4/87	Gangrene Rt foot & leg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/15, 1986, to 12/6/87, 1987, that (I) (we) last saw the deceased alive on 12/6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Max G. Sherer				12/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
MAX G. SHERER, M.D.	800 Pershing Dr. Silver Spring, Md 20910				
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	Dec. 8, 1987	Bnai Israel Cemetery	CITY OR TOWN COUNTY STATE		
			Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ives-Pearson Funeral Homes		DEC 09 1987		J. E. Swiden-Rendall	
NAME ADDRESS					
Falls Church, Va. 22046					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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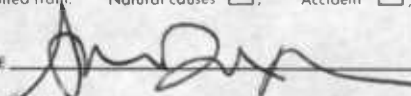
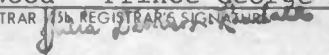
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DEC 16 1987

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN BRACKET IN ITEM 1E. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36161			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST 1787 BARBARA J. DUKE										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 12 11 87		2b. HOUR M 12 11 87	
3. SEX Female		4. RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 27 1965		6. AGE (IN YEARS) LAST BIRTHDAY 22		IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 11 87		2d. HOUR P.M. 2:20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Germantown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19534 Crystal Rock Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Germantown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 20874 19534 Crystal Rock Dr. Apt. 23			
14. FATHER'S NAME FIRST MIDDLE LAST Walter M. Murphy, Jr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Troiano									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213 90 0422		17. INFORMANT ADDRESS Warren A. Duke Same as 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Contact gunshot wound of left chest (handgun)</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? Body Only <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12-11- 19 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self-inflicted.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 19534 Crystal Rock Dr., Germantown, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12-12-87					
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE December 15, 1987		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince George MD					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25. DATE REC'D. BY REGISTRAR DEC 16 1987				25b. REGISTRAR'S SIGNATURE 					
Inc. 300 W. Montgomery Ave. Rockville, MD 20850													

07-84
25M

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(VR A15 ME (1))

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DHMH - 16 50M 1/81
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36162

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen B. Durand			2a. DATE OF DEATH MONTH DAY YEAR December 9, 1987		2b. HOUR 5:45p M				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 29, 1931		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Wrapper		12b. KIND OF BUSINESS OR INDUSTRY Giant Food	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 14226 Greenspan Lane/ 20853	
14. FATHER'S NAME FIRST MIDDLE LAST Henry C. Jacobs			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beatrice Paul			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 577-40-2164			17. INFORMANT ADDRESS Suzanne Durand 26 Parsons Grove Court Olney, Maryland 20832 (Daughter-In-Law)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>2 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Diabetes mellitus for 5 years</u>									
19a. DATE OF OPERATION <u>No</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. INCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, FURTHER MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN PART 11b OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>any</u> <u>1984</u> to <u>present</u> <u>19</u> , that (I) (we) last saw the deceased alive on <u>today</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE <u>James F. McMurkey Jr</u>				DEGREE <u>MD</u>		23b. DATE SIGNED <u>Dec 9, 1987</u>		23c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAMES F. McMurkey Jr</u>				23e. ADDRESS <u>6318 Democracy Blvd, Bethesda, MD</u>					
23f. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23g. DATE December 12, 1987		23h. NAME OF CEMETERY OR CREMATORY Mount Herman Church Cemetery		23i. LOCATION CITY OR TOWN COUNTY STATE Mount Jackson, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850				25a. DATE REC'D. BY REGISTRAR DEC 14 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the medical certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

075353 DEC 17 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36163

1. DECEASED NAME (TYPE OR PRINT) Althea A. Eccles			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1987		2b. HOUR 9:00P M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 23, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House		12a. USUAL OCCUPATION Dean of Court Reporters		12b. KIND OF BUSINESS OR INDUSTRY House of Representatives
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Potomac	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 10316 Democracy Lane/20854	
14. FATHER'S NAME FIRST MIDDLE LAST Andre Arceneaux		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amile Develier			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 220-32-6831		17. INFORMANT ADDRESS Althea E. Wallace, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Alzheimers Disease</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 7, 1986</u> to <u>December 12, 1987</u> , that (I) (we) last saw the deceased alive on <u>December 1, 1987</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George W. Graves</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/13/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George W. Graves, M.D.				22e. ADDRESS 916 19th Street, N.W. Washington, D.C. 20006	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 13, 1987	23c. NAME OF CEMETERY OR CREMATORY Inc. Montgomery Crematorium		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda Montgomery MD
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814				25a. DATE REC'D. BY REGISTRAR DEC 16 1987	
				25b. REGISTRAR'S SIGNATURE <u>Julia Benson-Randall</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

158-10-1105

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TO MEDICAL EXAMINER: THIS CERTIFICATE MUST BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

BP 943

07/84
25MDMMH - 17
(VR A15 ME (5))

075920

#18, 21 abcdef, 22a, Film G636
DEC 23 07
REGISTRAR 2/5/88 kam

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 3 6 1 6 4

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
DAVID			K.			EDELMAN			X MONTH 12 DAY 15 YEAR 87			M 11:45 P.M.							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR							
Male	White	Feb. 5, 1960	27 YRS.	MONTHS	DAYS	12 15 19 87													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Washington, D.C.			U.S.A.						Montgomery County MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Takoma Park			8206 Flower Ave.			Student			U. of Md.										
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Montgomery		Takoma Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		8206 Flower Avenue 20912	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
Seymour						Edelman						Hazel Thacher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT							
NO						219-68-4408						Seymour Edelman; Father; 9115 Glenridge Road Silver Spring, Md. 20910							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Smoke inhalation and thermal injury																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.																			
Alcohol intoxication																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
				11:30 12/15 19 87				House Fire											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				House				8206 Flower Avenue, Takoma Pk., Mont. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE						TITLE (SPECIFY)						DATE SIGNED							
Ann M. Dixon, M.D.						M.D. Deputy Chief						12-16-87							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS													
Ann M. Dixon, M.D.						111 Penn St., Balto., MD 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Cremation				12/21/87				Lee Crematory				Washington, D.C.							
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR								25b. REGISTRAR'S SIGNATURE							
DANZANSKY-GOLDBERG MEMORIAL CHAPELS				DEC 22 1987															
1170 Rockville Pike; Rockville, Md. 20852																			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36165

075954 DEC 23 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST HATTIE IOLA EDWARDS		12 18 87		9 08 PM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female	W	4 4 95	92 YRS	MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland	USA		Montgomery County MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital		Home Maker		Own Home		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE			
Maryland	Montgomery	Silver Spring		10303 Douglas Ave./20902			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS			
FIRST MIDDLE LAST Enock Garner		FIRST MIDDLE LAST Catherine Jane Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
No		213-38-0951		Mabel E. Kennon (Dau) -Same as #13-			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Pneumonia</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) _____							
DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12 Dec 1987</u> to <u>12 Dec 1987</u> , that (I) (we) lost <u>saw the deceased alive on above (I) (we) did (did not) see the body after death.</u>							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>[Signature]</u>		MD				19 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Michael Leibovich MD		1120 New Hampshire Ave SE, Apt 20404					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		12/22/87	Oakland Cemetery		Waldorf, Charles, Maryland		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Huntt Funeral Home		DEC 22 1987		Julia Gordon-Lindner			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36166

1- FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) RAYMOND Thaddeus EDWARDS			2a. DATE OF DEATH MONTH DAY YEAR 12 -31-1987		2b. HOUR 4:35 PM
3. SEX MALE	4. RACE Caucasion	5. DATE OF BIRTH MONTH DAY YEAR 07 -25-1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH TAKOMA PARK	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meatcutter		12b. KIND OF BUSINESS OR INDUSTRY Safeway
13a. STATE Maryland		13b. COUNTY Pr. Geor.	13c. CITY OR TOWN Hyattsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 3328 Lancer Drive 20782		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura B. Walker			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Edwards		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura B. Walker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS Helen Edwards Same as Line #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ISCHEMIC CARDIOMYOPATHY					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from DEC 29 19 87 to DEC 31 19 87 , that (I) (we) last saw the deceased alive on DEC 31 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Mark K. Li</i>		DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK K LI		22e. ADDRESS 1721 UNIVERSITY BLVD W, Wheaton MD 20902		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-4-88		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.		24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons, P.A. Hyattsville, Md. 20781			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John B. ...</i>			

RECEIVED

67753

JAN 5 1988

071245 NOV 1987

Items, 18a, & 22a., G-634, by Med. Exam.
FOR 12/21/87, Gbj.
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6167

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR							
Stephanie K. Elin						DATE ESTI. MATED			11 1 19 87			M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR					
female		Caucasian		Mar. 28, 1971		16 YRS.		MONTHS DAYS		HOURS MIN.		11 1 19 87		11:10 a M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland				United States								Montgomery County MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda				U.S. Naval Hospital				Student				School							
13a. STATE												13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland												Montgomery		Rockville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		11401 Marcliff Rd.,/20852	
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST						FIRST MIDDLE LAST													
Ronald J. Elin						Susan M. Krogh													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS							
no						217-70-7162						Ronald J. Elin-father- see #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Cardiac arrhythmia																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
22b. TITLE (SPECIFY)																			
Assistant MEDICAL EXAMINER																			
DATE SIGNED 11/2/87																			
EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle, Jr., M.D. ADDRESS 111 Penn St. Balto.MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial				Nov. 5, 1987		Gate of Heaven Cemetery				Silver Spring, Maryland									
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Md. 20850																			
25a. DATE REC'D BY REGISTRAR 12/15/87																			
25b. REGISTRAR'S SIGNATURE																			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84
25MDHMH - 17
(VR A15 ME (5))

011512 100-101 2102170

Item 6640 6-14-88

STATE OF MARYLAND

076917 DEC 31 1987

FOR
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 86163

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED		2c. MONTH		2d. DAY		2e. YEAR		2f. HOUR	
George Lawrence Elliott								12-27 19 87		12-27 19 87								9:00 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD		10. MONTH		11. DAY		12. YEAR		13. HOUR	
Male	White	8-24-1949		38		MONTHS		DAYS		12-27 19 87								9:00 P.M.	
7a. BIRTHPLACE (STATE OR COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MONTH		11. DAY		12. YEAR		13. HOUR		14. MIN.	
Maryland		United States		WIDOWED		DIVORCED		Montgomery County,										MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. CITY OR TOWN		14. STATE		15. ZIP CODE		16. COUNTY		17. ZIP CODE		18. ZIP CODE	
Silver Spring		Holy Cross Hospital		Printer		U 81 Md.		Beltsville		Maryland		20705							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY		13c. INSIDE CITY LIMITS?		13d. ADDRESS		14. CITY OR TOWN		15. STATE		16. ZIP CODE		17. COUNTY		18. ZIP CODE		19. ZIP CODE	
Maryland		Beltsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		11236 Cherry Hill Rd. #204 20705													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. CITY OR TOWN		20. STATE		21. ZIP CODE		22. ZIP CODE	
George A. Elliott		Agnes Tyler Tyler		No		212-54-1228		Agnes Mitchell		4502 Wicomico Ave. 20705									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		BRONCHIAL ASTHMA		DUE TO, OR AS A CONSEQUENCE OF		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D.		DATE SIGNED		12-28-87													
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. DATE REC'D. BY REGISTRAR		25. REGISTRAR'S SIGNATURE									
Cremation		12-31-1987		Metropolitan Crematory		Alexandria Fairfax Virginia		DEC 31 1987											
26. NAME		4400 Powder Mill Road Beltsville, Maryland 20705																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

07/84
25M

BP

DHMH - 17
(VR A15 ME (5))

1987 10 15

LIBRARY COLLECTION

WALTON

076691 DEC 31 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36169

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADELE ELLIS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1987		2b. HOUR 8:10P M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR DEC 23 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SIL. SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR ELLIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE AKARI		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-01-7895		17 INFORMANT BROTHER ARTHUR J. ELLIS		ADDRESS 3001 VEAZEY TERRACE WASHINGTON, DC 20008			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 6 OCT 19 87 to 24 DEC 19 87, that (I) saw the deceased alive on 5 DEC 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.							
22b. SIGNATURE WALTER E. GOOLZ MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 25 DEC 87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOOLZ MD		22e. ADDRESS 2309 SHOREFIELD ROAD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 30, 1987		23c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, D.C.	
24 FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

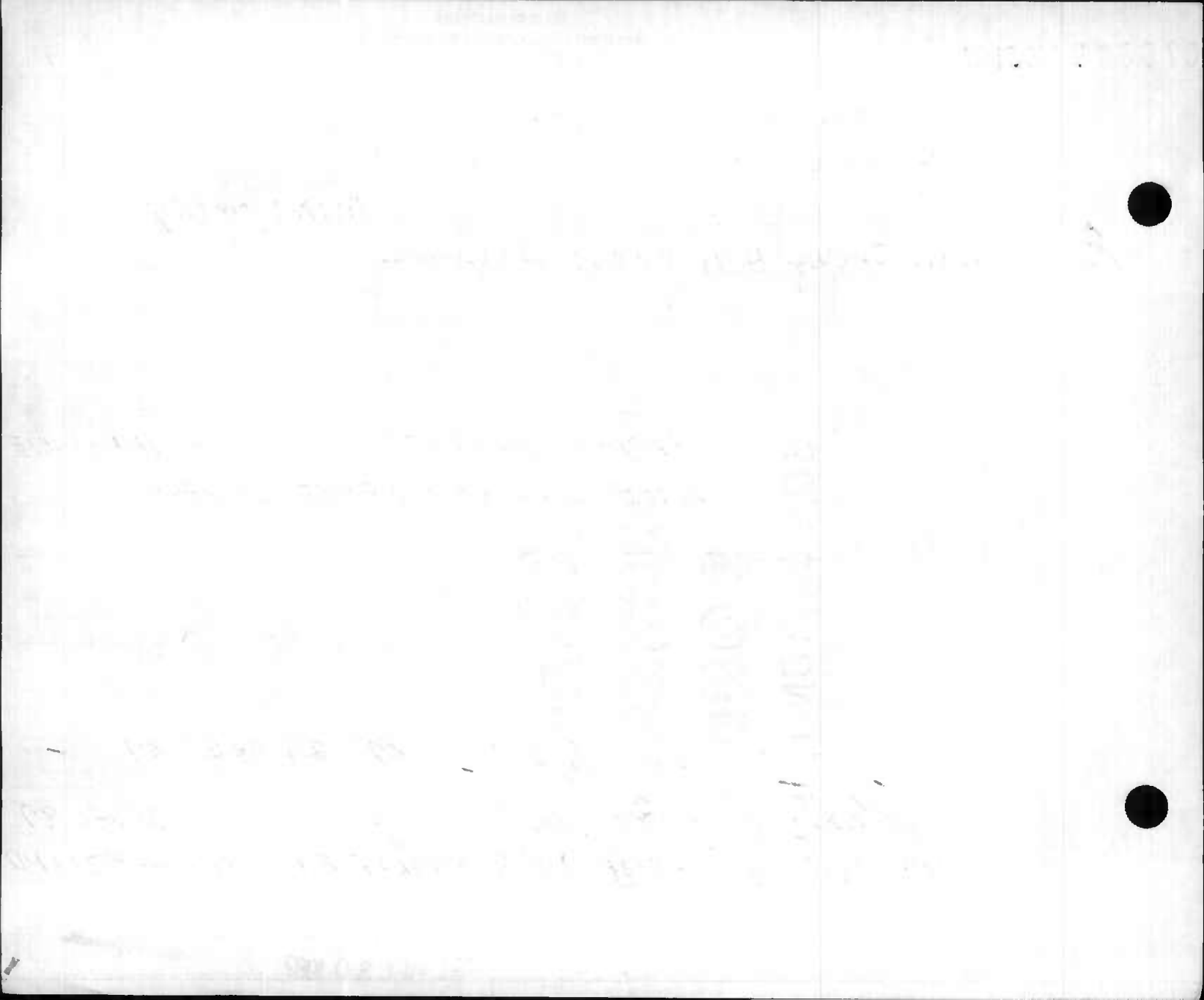
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)



075368 DEC 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) CARL G ENGLING JR									
2a. DATE OF DEATH MONTH 12 DAY 9 YEAR 87									
2b. HOUR 12:45 P									
3. SEX MALE		4. RACE W		5. DATE OF BIRTH MONTH 6 DAY 16 YEAR 40		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FIRE FIGHTER		12b. KIND OF BUSINESS OR INDUSTRY WASH. D.C.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
13e. STREET ADDRESS / ZIP CODE 3315 B HAMPTON POINT DR. 20904									
14. FATHER'S NAME FIRST CARL MIDDLE G. LAST ENGLING, SR. 15. MOTHER'S MAIDEN NAME FIRST JUNE MIDDLE LAST YOWELL									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. 578-52-9470 17. INFORMANT ADDRESS MARY JEAN ENGLING/WIFE/SAME AS 13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) Diabetes Mellitus									
19a. DATE OF OPERATION Dec 8 19 87 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) 									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 									
22a. I certify that (I) (the hospital) attended the deceased from Dec 8 19 87 to Dec 9 19 87 , that (I) + last saw the deceased alive on Dec 9 19 87 , and that in (my) + opinion death occurred on the date and hour and from the causes stated above, (I) + (did not) view the body after death.									
22b. SIGNATURE Francis J. Collins, MD DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 12/9/87									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Francis J. Collins 22e. ADDRESS 10813 Georgia Ave, Silver Spring, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE DEC 12, 1987 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD									
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 25a. DATE REC'D. BY REGISTRAR DEC 16 1987 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

BP

My dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter. I am sorry to hear that you are not satisfied with the result of the investigation. I have, however, no objection to your making such use of the facts as you may think proper. I am, Sir, very respectfully,
Yours truly,
J. B. [Name]

I am, Sir, very respectfully,
Yours truly,
J. B. [Name]

1870

076223 DEC 28 1987

#7b, per F.H. 2/4/88 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36171

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELEANOR ROSEMARY FINBERG			2a. DATE OF DEATH MONTH DAY YEAR 12 16 87		2b. HOUR 10:21 A M						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 25 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) FRANCE		7b. CITIZEN OF WHAT COUNTRY? Great Britain		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER		12b. KIND OF BUSINESS OR INDUSTRY CATHOLIC SCHOOLS			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 10409 BURNT EMBER DRIVE 20903			
14. FATHER'S NAME FIRST MIDDLE LAST DOUGLAS			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SCHUMANN								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 165-40-1519		17. INFORMANT ADDRESS JOHN A. FINBERG HUSBAND SAME AS 13							
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>Doxorubicin Therapy</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Disseminated Medullary Carcinoma of Thymid 6 Yrs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>less than 1 day</u> <u>1 week</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (was hospital) attended the deceased from <u>July 3</u> 19 <u>86</u> , to <u>12/16</u> 19 <u>87</u> , that (I) (was) saw the deceased alive on <u>12/16</u> 19 <u>87</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. Lennard Gold, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/16/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. LENNARD GOLD, M.D.				22e. ADDRESS 8630 FENTON ST. SILVER SPRING, MD. 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE DEC. 19, 1987		23c. NAME OF CEMETERY OR CREMATORY METROPOLITAN CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE ALEXANDRIA VIRGINIA					
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD., W. SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rudolph</u>			

077103 JAN

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG 30172

1- FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH										2b. HOUR															
DECEASED NAME (TYPE OR PRINT) Mary Louise Flaherty										DATE KNOWN OF DEATH ESTI MATED Dec. 30 19 87										HOUR A M															
3. SEX Female		4. RACE Caucas.		5. DATE OF BIRTH Aug. 22, 1923		6. AGE (IN YEARS) 64 YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD Dec. 30 19 87										HOUR 08 PM M													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York				7b. CITIZEN OF WHAT COUNTRY? United States				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD																							
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 7809 Winterberry Place								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary								12b. KIND OF BUSINESS OR INDUSTRY Insurance															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																																			
13a. STATE Maryland				13b. COUNTY Montgomery				13c. CITY OR TOWN Bethesda				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 7809 Winterberry Place/20817																			
14. FATHER'S NAME William S. Ensign								15. MOTHER'S MAIDEN NAME not available																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no								16b. SOCIAL SECURITY NO. 219-12-4598								17. INFORMANT ADDRESS Roger Flaherty, same as #13																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE																																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																																			
19a. DATE OF OPERATION								19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH								21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR AM P.M. 12 30 19 87								21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FOUND DEAD IN BED																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK								21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME								21f. LOCATION CITY OR TOWN COUNTY STATE 7809 WINTERBERRY PL. BETHESDA MONT MD																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																																			
ACTUAL SIGNATURE Francis C. Mayle, M.D.																TITLE (SPECIFY) Deputy MEDICAL EXAMINER																			
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D.																DATE SIGNED Dec. 30, 1987																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial																23b. DATE Jan. 2, 1988				23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery								23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland							
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814																25a. DATE RECEIVED BY REGISTRAR JAN 4 1988																			
25b. REGISTRAR'S SIGNATURE																																			

07/84
25M

BP

DHMH - 17
(VR A15 ME (1))

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REPT. MOTION

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035103

076611 DEC 31 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove distribution pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or has 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

999999
BP
DHMH 10 60M 7/84
(VIA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. **87 36173**

1. DECEASED NAME (TYPE OR PRINT) Mary T. Flannery			2a. DATE OF DEATH MONTH 12 DAY 29 YEAR 87		2b. HOUR 3:00AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Jan. DAY 15 YEAR 1909	6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Olney	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE New Jersey		13b. COUNTY UNK	13c. CITY OR TOWN Elizabeth	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 331 Elmora Avenue 99999
14. FATHER'S NAME FIRST Frank MIDDLE LAST Travers		15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE LAST Hurley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 141 30 2889		17. INFORMANT 540 Washington St. Bond Brooke, Marybeth Schleck (Daughter) N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/24/87
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Respiratory Failure					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (a) this hospital attended the deceased from 12/29 , 19 87 to 12/29 , 19 87 , that (b) we last saw the deceased alive on 12/29 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John G. Lodmeyer		DEGREE MD		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN G. LODMEYER, MD.		22e. ADDRESS 2901 Olney Sandy Spring Rd. Olney Md. 20832			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/2/88		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Newark, New Jersey	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR DEC 30 1987			
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hampshire Ave. S.S.Md.		25b. REGISTRAR'S SIGNATURE Julia Anderson-Randall			

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2020 COLLECTION

76827 DEC 31 1987

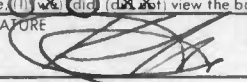

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/B4
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. DECEASED NAME (TYPE OR PRINT) George Elmer Flather, Jr.					2a. DATE OF DEATH MONTH DAY YEAR December 19, 1987		2b. HOUR 5:00 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 18 18		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 9503 Duffer Way				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Banker/lawyer		12b. KIND OF BUSINESS OR INDUSTRY Banking		
13a. STATE MD.					13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George Elmer Flather, Sr.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Postles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (US Navy)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT Carolyn A. Flather		ADDRESS Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicaemia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 hr.	
DUE TO, OR AS A CONSEQUENCE OF (b) Peripheral vascular insufficiency									1 month	
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis									7 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Cerebrovascular accident										
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR NA			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> NA			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) NA			21f. LOCATION STREET CITY OR TOWN COUNTY STATE NA				
22a. I certify that (I) (this hospital) attended the deceased from 12/16 , 19 87 , to 12/19 , 19 87 , that (II) <input checked="" type="checkbox"/> saw the deceased alive on 12/19 , 19 87 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death.)										
22b. SIGNATURE 						DEGREE M. D.		22c. DATE SIGNED 12/21/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. William Harter, M.D.						22e. ADDRESS 9705 Hall Road Potomac, MD. 20854				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/22/87		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.		
24. FUNERAL DIRECTOR NAME Jos. Gawler & Sons						ADDRESS 5130 Wisconsin Ave NW		25. DATE REC'D. BY REGISTRAR DEC 30 1987		
25b. REGISTRAR'S SIGNATURE 										

MEDICAL CERTIFICATION

7 6 8 3 7 DEC 31 1987

December 19, 1987

Walter, Jr.

George

White

Male

Walter A. Walter

DEC 30 1987

074746 DEC 11 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it must be submitted to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department within 24 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 4.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sarah E. FLEMING					2a DATE OF DEATH MONTH DAY YEAR December 8, 1987		2b HOUR MIN. 6 AM		
3 SEX Female		4 RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Oct. 22, 1918		6 AGE (IN YEARS LAST BIRTHDAY) YRS 69		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10 CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 352 N. Summit Ave., 001				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 352 N. Summit Ave., 001 20877	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Fleming				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Sarah Brown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 212-24-4754		17 INFORMANT ADDRESS 14024 Breeze Hill La. Silver Spring, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery Disease Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last: (c) Diabetes DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-15 , 19 85 , to 11-19 , 19 87 , that (I) (we) last saw the deceased alive on 11-19 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Tibor E. Frekko</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED Dec. 9, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Tibor E. Frekko, M.D.				22e ADDRESS 19211 Montgomery Village Ave., Gaithersburg, Md.					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 11, 1987		23c NAME OF CEMETERY OR CREMATORY Friendship		23d LOCATION CITY OR TOWN COUNTY STATE Damascus, Montgomery, Md.			
24 FUNERAL DIRECTOR Blain L. Molesworth, P.A., Damascus, Md.				25a DATE REC'D. BY REGISTRAR DEC 10 1987		25b REGISTRAR'S SIGNATURE <i>John L. Molesworth</i>			

BP

77575 JAN 11 1988

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 3 6 1 7 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RUSSELL WATSON FLUHARTY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31 1987		2b. HOUR 1010pm
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 12 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED - Naval	12b. KIND OF BUSINESS OR INDUSTRY NONE
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MARYLAND QUEEN ANNE'S		13b. CITY OR TOWN Stevensville		13c. STREET ADDRESS / ZIP CODE BOX 16-5 21666	
14. FATHER'S NAME FIRST MIDDLE LAST WATSON NMN FLUHARTY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA BELLE MORGAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1939-1962	17. INFORMANT ADDRESS HELEN FLUHARTY BOX 16-5 BAY CITY, MD 21666		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 09 1987 , to DECEMBER 31 1987 , that (I) lost saw the deceased alive on DECEMBER 31 1987 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was did not view the body after death.					
22b. SIGNATURE Sarah G. Fellows				22c. DATE SIGNED 31 DEC 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SARAH G. FELLOWS, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 21 20814-5011	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 01/04/88	23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Denton Caroline MD
24. FUNERAL DIRECTOR NAME ADDRESS Tom Helfenbein Funeral Home, Chester, MD 21619			25a. DATE REC'D. BY REGISTRAR JAN 7 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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Level -

Greenhills

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London London London

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JAN 7 1988

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36177

FOR STATE REGISTRAR		Nephtune		Fogelberg		REG. NO.		87 36177	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR		PM	
NEPTUNE		FOGELBERG		12 4 87		12:52		M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
M		White		8/09/104		83 YRS		IF UNDER 24 HRS HOURS MINS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Utah		USA				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
S.S.		Holy Cross Hospital		US Gov't.		Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Md.		Mont		S.S.				511 Warrenton Drive 20904	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFLUENZA	
Wilhelm Fogelberg		Vendla Bernsten		Yes		WWII 579 35 5570		2124 Park Dale East Encinitas, Ca.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Respiratory Failure		Chronic Obstructive Lung Disease		Cigarette Smoking		Months		Years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						60 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 11/22 19 87, to Present, that (2) (we) lost saw the deceased alive on 11/22 19 87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
IRVING S. OSER		10301 GEORGIA AVE SILVER SPRING MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN) COUNTY STATE			
Cremation		12/5/87		Metropolitan Crematory Alex.Va.					
24. FUNERAL DIRECTOR'S NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Rinaldi 11800 New Hamp.Ave. S.S.Md.		DEC-7-1987		Julia Gordon-Randall					

BP

NO. 1: 56830

076100 DEC 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1001. PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 86178	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM L FORD						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 12 22 87		2b. HOUR 22 40			
3. SEX Male		4. RACE Cauc		5. DATE OF BIRTH MONTH DAY YEAR 08 10 02		6. AGE (IN YEARS) (LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 22 87	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Public Relations		12b. KIND OF BUSINESS OR INDUSTRY C&S Telephone			
13a. STATE MD						13b. COUNTY MONTGOMERY		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Michael MIDDLE J. LAST Ford						15. MOTHER'S MAIDEN NAME FIRST Not Available MIDDLE Fitzpatrick LAST Fitzpatrick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 233-10-0915		17. INFORMANT ADDRESS Barbara Doyle 6803 Breezewood Terrace Rockville, Maryland 20852 (Daughter)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ACUTE Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). DIABETES MELLITUS											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12 P.M. 12 22 87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED AT HOME					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 6803 Breezewood Terrace Rockville Mont Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE FRANK C MAYLE				TITLE (SPECIFY) M.D. DIST				DATE SIGNED 12/23/87			
EXAMINER'S NAME (TYPE OR PRINT) FRANK C MAYLE				ADDRESS 6803 Breezewood Terrace Rockville, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE December 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wheeling, West Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Bethesda-Cherry Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE			

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[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of" are faintly visible.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8736179

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		2a. DATE OF DEATH		MONTH	YEAR	7b. HOUR	
Josephine A. Fortney							December 8, 1987				6:15 pm	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.		
Female		White		MONTH DAY YEAR December 17 1918		68 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Colorado		U.S.A.				Montgomery County MD						
11a. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Kensington		10108 E. Bexhill Dr.				Registered Nurse		Private				
13a. STATE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS / ZIP CODE		
Maryland						Montgomery		Kensington		10108 E. Bexhill Dr. 20895		
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Joseph Frank Anderson						FIRST MIDDLE LAST Blanche Markle						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
no		522-42-5638		Evelyn A. Mote, Same as item 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>COAD</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY SYSTEM IN PART 1 OR PRINT IT)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>11/20/87</u> to <u>12/8/87</u> that (I) (we) last saw the deceased alive on <u>11/20/87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.												
22b. SIGNATURE <u>Isa Taubert</u> DEGREE <u>MD</u>						22c. DATE SIGNED <u>12/9/87</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Isa Taubert</u>						22e. ADDRESS <u>10301 Georgia Ave</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Cremation		12-9-87		Metropolitan Crematory		Alexandria, Virginia						
24 FUNERAL DIRECTOR NAME Richard Rapp, Inc. P. O. Box 43352, Washington, DC 20010						25a. DATE REC'D. BY REGISTRAR <u>DEC 11 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Sanders-Radabaugh</u>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, indicate same on the next page.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, indicate how you will be notified and how

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column pages. Pages heard 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of (circled)

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

DOLORES T.

FRAYLICK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

36180

1. DECEASED NAME (TYPE OR PRINT) DOLORES T FRAYLICK			2a. DATE OF DEATH MONTH DAY YEAR 12 28 87			2b. HOUR 550 A			
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 07 28		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MD.		13b. COUNTY MONT.		13c. CITY OR TOWN GAITHERSBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 10408 MERCADO WAY 20879	
14. FATHER'S NAME FIRST MIDDLE LAST STANLEY - HUYLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN - BRODERICK						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 103-20-1182		17. INFORMANT NORBERT R. FRAYLICK SAME AS #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Leukopenia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Non-Hodgkin's Lymphoma</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day few days 5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>7/18</u> 19 <u>83</u> to <u>12/2</u> 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>12/1</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>G. Leonard Gold</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/2/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. G. LEONARD GOLD						22e. ADDRESS SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE DEC. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT. MD.		
24. FUNERAL DIRECTOR MURIEL H. BARBER LAYTONSVILLE, MD. 20879						25. DATE REC'D. BY REGISTRAR 76 REGISTRAR'S SIGNATURE DEC - 4 1987 <u>Julia Davidson-Rudolph</u>			

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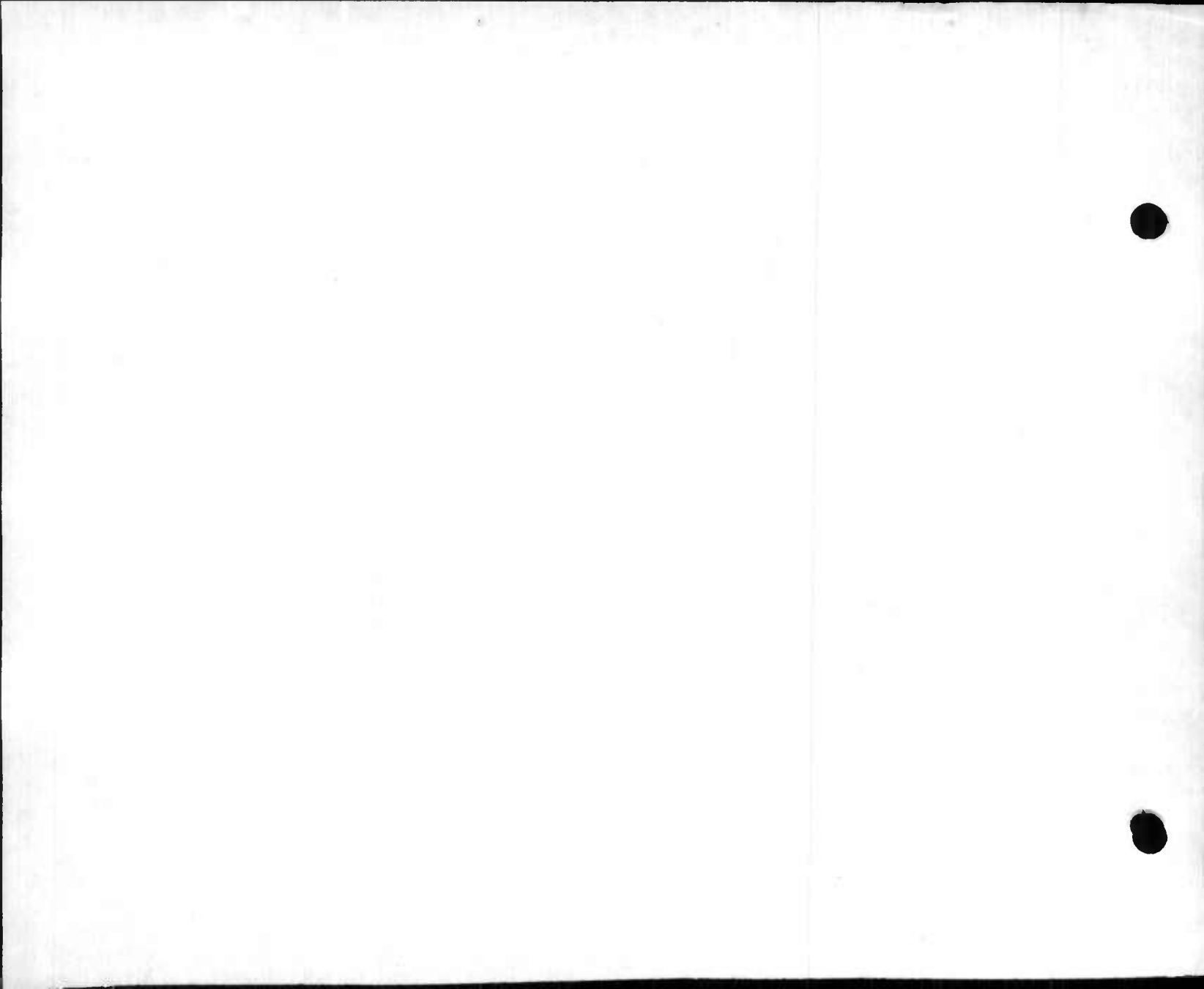
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VOID

CERTIFICATE # 87 36181



76552 DEC 30 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/74
(VIA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) JULIA V. FRETTELL					2a. DATE OF DEATH MONTH DAY YEAR 12-27-87					2b. HOUR MIN 7:10 A	
3. SEX Female		4. RACE FWNITE		5. DATE OF BIRTH MONTH DAY YEAR 7-28-14		6. AGE (IN YEARS LAST BIRTHDAY) 73		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Peru		7b. CITIZEN OF WHAT COUNTRY? Peru		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery. MD.					
10. CITY OR TOWN OF DEATH Silver Spring.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House wife.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1017 Quebec Terrace Apt 2 20903			
14. FATHER'S NAME FIRST MIDDLE LAST Victor Quispe					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Zoraida Rodriquez						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 579-94-8166		17. INFORMANT Emilio Fretell		ADDRESS 13 e. Husband.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROSIS										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 87 , to 12/27 , 19 87 , that (I) (we) lost saw the deceased alive on 12/27 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Hector K. Collison					22c. DATE SIGNED 12/29/87			22d. PHYSICIAN'S NAME (TYPE OR PRINT) HECTOR K. COLLISON MD			
22e. ADDRESS 1111 SPRING ST - SILVER SPRING											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 30, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate Of Heaven			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Sprg. Montg. Md.			
24. FUNERAL DIRECTOR Monika Funeral Home					25a. DATE REC'D BY REGISTRAR DEC 29 1987			25b. REGISTRAR'S SIGNATURE [Signature]			
25c. ADDRESS 254 Carroll St. N. W. D. C.											

MEDICAL CERTIFICATION

1887-1888

[Faint, mostly illegible text, possibly a ledger or account book. Some visible words include "Total", "Balance", and "Paid".]

DEC 2 1887

074313 DEC

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 36183

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) L Y D I A			2a. DATE OF DEATH MONTH DAY YEAR 12/3/87			2b. HOUR 12 30 P.M.			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 3 - 8 - 04		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Carson Pirie Scott, Inc.	
13a. STATE MD		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1429 Colesberg St 20904	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Schultz			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Marquardt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Lois Miller-daughter-(same as 13e)		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>atrial fibrillation</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>87</u> to <u>present</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/2</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Luis A. Casas MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/3/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LUIS A. CASAS MD			22e. ADDRESS 8317 CHERRY LA. LAUREL MD 20707						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12-5-1987		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY Alexandria Virginia		
24. FUNERAL DIRECTOR Hines, Rinaldi Funeral Home 11800 N.H. Ave. Silver Spring, Md.					25a. DATE REC'D. BY REGISTRAR DEC-7 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Pedraza</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

01/13/13 DEC-9-93

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[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

DEC-9-93

075372 DEC

Film G636 item 6

STATE OF MARYLAND

FOR 2/5/88 rja Film G645 Item DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 1- STATE REGISTRAR 15 11/2/88 cy
CERTIFICATE OF DEATH

87 36184

1. DECEASED NAME (TYPE OR PRINT) EDITH COOKE FULLER		2a. DATE OF DEATH MONTH DAY YEAR 12 12 87		2b. HOUR 9:20 P.M.	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 18 1907		6. AGE (IN YEARS LAST BIRTHDAY) 90 80 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ILLINOIS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1606 DALE DRIVE		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST CHESTER J. COOKE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL Eleta Aleta RUSSELL			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 336-16-0126		17. INFORMANT ADDRESS NATHAN F. FULLER/HUSBAND/SAME AS 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio resp. arrest DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 3 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH terminal
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-7-87 to 12-12-87 , that (I) (last saw the deceased alive on 12-7-87), and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) not view the body after death.					
22b. SIGNATURE George Senestack MD				22c. DATE SIGNED 12-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE SENESTACK				22e. ADDRESS 3929 FERRARA DRIVE WHEATON, MD 20906	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DEC 16, 1987	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM	23d. LOCATION (CITY OR TOWN) COUNTY STATE SILVER SPRING MONTGOMERY MD
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25a. DATE REC'D. BY REGISTRAR DEC 16 1987	25b. REGISTRAR'S SIGNATURE Alia Twicken-Randall

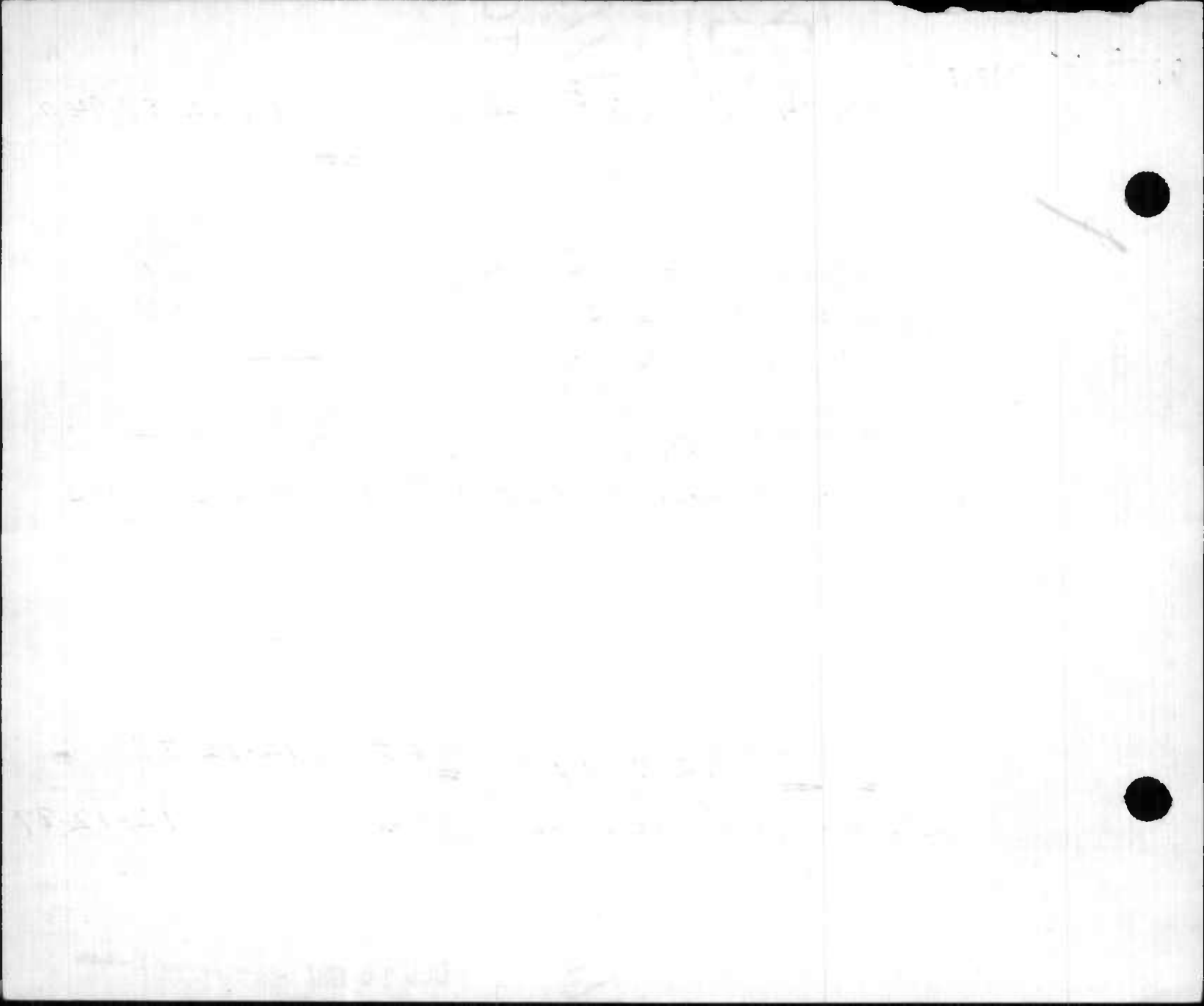
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, then any injury, accident, or traumatic event, the medical examiner must be notified of at once.

BP



076537 DEC 30 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 1/81
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) Anne		FIRST MIDDLE LAST Furash		2. DATE OF DEATH MONTH DAY YEAR 12/24/87		2b. HOUR 1900	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 04 14 05		6. AGE (IN YEARS, LAST BIRTHDAY) 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 6121 Montrose Road		13f. STREET ADDRESS 20852		13g. STREET ADDRESS 6121 Montrose Road		13h. STREET ADDRESS 6121 Montrose Road	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Kirsch		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Zakorsky		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579 03 8730	
17. INFORMANT David G. Kirsch		18. ADDRESS P.O. Box 402304, Miami, FLA.		19. ADDRESS 33140		20. ADDRESS 33140	
21. ADDRESS 33140		22. ADDRESS 33140		23. ADDRESS 33140		24. ADDRESS 33140	
25. ADDRESS 33140		26. ADDRESS 33140		27. ADDRESS 33140		28. ADDRESS 33140	
29. ADDRESS 33140		30. ADDRESS 33140		31. ADDRESS 33140		32. ADDRESS 33140	
33. ADDRESS 33140		34. ADDRESS 33140		35. ADDRESS 33140		36. ADDRESS 33140	
37. ADDRESS 33140		38. ADDRESS 33140		39. ADDRESS 33140		40. ADDRESS 33140	
41. ADDRESS 33140		42. ADDRESS 33140		43. ADDRESS 33140		44. ADDRESS 33140	
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49. ADDRESS 33140		50. ADDRESS 33140		51. ADDRESS 33140		52. ADDRESS 33140	
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89. ADDRESS 33140		90. ADDRESS 33140		91. ADDRESS 33140		92. ADDRESS 33140	
93. ADDRESS 33140		94. ADDRESS 33140		95. ADDRESS 33140		96. ADDRESS 33140	
97. ADDRESS 33140		98. ADDRESS 33140		99. ADDRESS 33140		100. ADDRESS 33140	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36186

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (Type or Print) Ruth R. Gaist			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1987		2b. HOUR 11:00 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 17 93		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ENGLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASH.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY None	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Morris Shofnos			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-09-0184		17. INFORMANT ADDRESS Milton Aronson (Nephew) 20852 11400 Strand Dr. Apt. 403 Rockville, MD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) Failure to thrive		
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral Vascular Accident + Atherosclerotic Heart		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Distant		

19a. DATE OF OPERATION —	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/26 to 12/17 , 19 87 , that (I) (we) last saw the deceased alive on 12/17 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.			
22b. SIGNATURE Merlyn Vemury MD		DEGREE MD	22c. DATE SIGNED 12/17/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MERLYN VEMURY		22e. ADDRESS HEBREW HOME OF GREATER WASH MONTROSE RD ROCKVILLE, MD	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal	23b. DATE 12-17-87	23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. University Medical School	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.
24. FUNERAL DIRECTOR NAME Columbia Mortuary Services Inc.		DATE REC'D. BY REGISTRAR DEC 21 1987	
225 Missouri Ave. N.W. Wash. D.C. 20011		REGISTRAR'S SIGNATURE Deborah R. Rader	

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 03-03-01 BY 60321

1952 JAN 31

11-49

RECEIVED
JAN 31 1952
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.
OFFICE OF THE SECRETARY
ATTENTION: ASSISTANT SECRETARY
FOR AGRICULTURAL MARKETING
SERVICES
FROM: [illegible]
SUBJECT: [illegible]

Enclosed for the Department of Agriculture
are two copies of a report on the
marketing of agricultural products
in the State of [illegible]. The report
contains information on the production,
distribution, and marketing of these
products in the State.

Very truly yours,
[illegible]
[illegible]
[illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36187

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ricardo		FIRST Garcia		LAST		2a. DATE OF DEATH MONTH 12 DAY 28 YEAR 1987		2b. HOUR 4:30 P.M.	
3. SEX male		4. RACE N		5. DATE OF BIRTH MONTH 3 DAY 28 YEAR 39		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS 58 DAYS 58 HOURS 58 MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SPAIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Natl. 4-H Council		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENNESAW		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4222 McCain Ct 20795	
14. FATHER'S NAME FIRST Josie MIDDLE Garcia LAST Garcia		15. MOTHER'S MAIDEN NAME FIRST Salvadora MIDDLE Unknown LAST Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-52-5161		17. INFORMANT ADDRESS Encarnacion Garcia (Wife) Same as 13E					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic bladder cancer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) _____	
DUE TO, OR AS A CONSEQUENCE OF		(c) _____	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/26 , 19 87 , to 12/28 , 19 87 , that (I) (we) last saw the deceased alive on 12/26 , 19 87 , and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE Peter Sherer		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Peter Sherer MD		22e. ADDRESS 3947 Ferrara Dr. Wheaton Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi 11800 New Hamp. Ave. S.S. Md.				25a. DATE REC'D. BY REGISTRAR DEC 30 1987		25b. REGISTRAR'S SIGNATURE Gia Ender-Radner	

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15007

WHEAT FLOUR

100 LBS

100 LBS

100 LBS

074880 DEC 14 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36188
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Frederick Garvin			2a. DATE OF DEATH MONTH DAY YEAR December 1, 1987		2b. HOUR 6A M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 10 1942		6. AGE (IN YEARS (LAST BIRTHDAY)) 45 YRS IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Damascus		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 25011 Woodfield Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ft. End Spec.		12b. KIND OF BUSINESS OR INDUSTRY Auto		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Damascus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST James Clifton Garvin			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Bliss Smith				13e. STREET ADDRESS / ZIP CODE 25011 Woodfield Rd. 20872	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam		17. INFORMANT Shirley Jones, Item 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic Metastatic Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma, Colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ulcerative Colitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months UNCERTAIN 27 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>JAN 30</u> , 19 <u>78</u> , to <u>Dec 1</u> , 19 <u>87</u> , that (I) <u>(was)</u> last seen the deceased alive on <u>Nov 33</u> , 19 <u>87</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(did not)</u> view the body after death.								
22b. SIGNATURE <u>John E. Kilfeather MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/4/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN E. KILFEATHER, MD				22e. ADDRESS 8301 ARLINGTON BLVD FAIRFAX, VIRGINIA 22031				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 5, 1987		23c. NAME OF CEMETERY OR CREMATORY Midland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Midland, Virginia		
24. FUNERAL DIRECTOR NAME Oliver L. Moxesworth, P.A.				ADDRESS Damascus, Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1987		
				25b. REGISTRAR'S SIGNATURE Julia D. ...				

MEDICAL CERTIFICATION

9187

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

075945 DEC 28-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 38189

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOTTIE GASTON.			2a. DATE OF DEATH MONTH DAY YEAR DEC. 20-1987		2b. HOUR 5A. M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7/26/15		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CANADA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY CONVALESCENT NURSING HOME		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
12a. USUAL OCCUPATION (TYPE OF WORK, MANUFACTURING, SERVICE, ETC.) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. STATE MD.			13b. COUNTY MONTG.		13c. CITY OR TOWN SSPG.	
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM FEIMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH BENDER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 058-26-2970		17. INFORMANT ADDRESS 1005 LAMBERTON DR.; SSPG, MD. MR. OSCAR GASTON (HUSBAND)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Cerebrovascular accident						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 85 , to 12/20 , 19 87 , that (I) (we) last saw the deceased alive on 12/20 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.						
22b. SIGNATURE Myron L. Lenkin				22c. DATE SIGNED 12/24/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. MYRON L. LENKIN				22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD.		
23a. BURIAL, CREMATION, REMOVAL METHOD BURIAL		23b. DATE 12-21-87		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM.		
23d. LOCATION CITY OR TOWN ADELPHI MD.		23e. COUNTY MT.		23f. STATE MD.		
24. FUNERAL DIRECTOR DANILANSKY-GOLDBERG MEM. CHP. INC. 1170 ROCKVILLE PK. ROCKVILLE MD.				25. DATE REC'D. BY REGISTRAR DEC 22 1987		
				25b. REGISTRAR'S SIGNATURE Julia Brinson-Randall		

MEDICAL CERTIFICATION

078020 JAN 13 1988

Item 17, Film G636 2-18-88 dw

FOR STATE REGISTRAR per funeral home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36190

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LOULA HART GEARY			2a. DATE OF DEATH MONTH DAY YEAR December 30, 1987		2b. HOUR 9:35P M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR November 21, 1897		
6. AGE (IN YEARS LAST BIRTHDAY) 90		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		8. CITIZEN OF WHAT COUNTRY? U.S.A.		
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		10. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
12. CITY OR TOWN OF DEATH Silver Spring		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Althea Woodland Nursing Home		14. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE Virginia		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS 8601 Brook Road		
18. FATHER'S NAME FIRST MIDDLE LAST Harry B. Hart		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Glendora Johnson		20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		22. SOCIAL SECURITY NO. 263-78-5140		23. INFORMANT MARGERY PFLUG Marjorey Pflug, 8601 Brook Rd., McLean, Va.		
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Cerebro Vascular Accident, Peripheral Vascular Disease, Pneumonia</u>						
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE		
29. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
30. SIGNATURE Bernard A. Fitzgerald MD				31. DEGREE MD		
32. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				33. ADDRESS 217 University Blvd E, Silver Spring, MD		
34a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		34b. DATE Jan 4, 1988		34c. NAME OF CEMETERY OR CREMATORY Forest Lawn Central		
35a. FUNERAL DIRECTOR NAME Money & King Vienna Funeral Home		35b. DATE REC'D. BY REGISTRAR JAN 12 1988		35c. REGISTRAR'S SIGNATURE		
36a. ADDRESS 171 W. Maple Ave., Vienna, Va.		36b. LOCATION CITY OR TOWN COUNTY Fort Lauderdale, Florida		36c. DATE 2-29-90		

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMM 16-60MM/73
(VR A-15 (4))

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36191

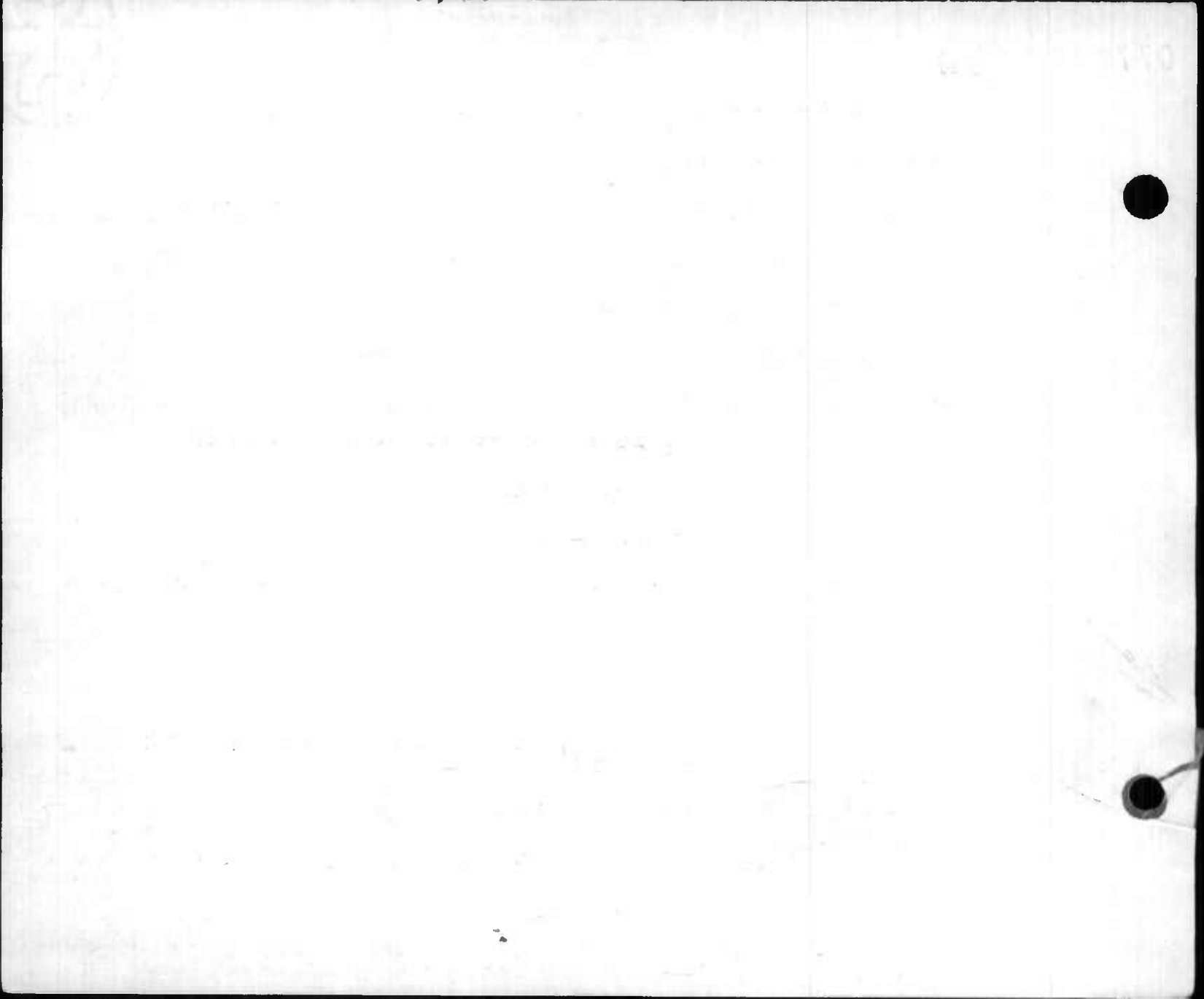
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjorie M. Geddes MARJORIE M. GEDDES		2a. DATE OF DEATH MONTH DAY YEAR 12-21-87		2b. HOUR 6:55 P.M.	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ill.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin. Assistant	12b. KIND OF BUSINESS OR INDUSTRY CBS News	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 4609 Bayard Blvd. 20816
14. FATHER'S NAME FIRST MIDDLE LAST Arthur R. Merrick			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude Cavin		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 579-42-7605		17. INFORMANT ADDRESS Ellin G. Leon (Daughter) Potomac, Maryland 8713 Crider Brook Way	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) SEPSIS DUE TO, OR AS A CONSEQUENCE OF (c) DECUBITI					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CEREBROVASCULAR ACCIDENT; DISSECTING ANEURYSM					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-13 , 19 87 , to 12-21 , 19 87 , that (I) (we) lost saw the deceased alive on 12-13 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE John Tauber		DEGREE MD		22c. DATE SIGNED 12-21-87 MD.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Tauber		22e. ADDRESS 8218 WISCONSIN AVE, Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Dec. 24, 1987	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.	
24. FUNERAL DIRECTOR NAME DeVol Funeral Home		ADDRESS 2222 Wisc. Ave. Washington, D.C.		25a. DATE REC'D BY REGISTRAR JAN 4 1988	
				25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please deliver this certificate to the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 361-92

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JACK GERSHANOV		2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 24, 1987		2b. HOUR 12:40 P	
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH AUGUST 4, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 69	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT-OWNER		12b. KIND OF BUSINESS OR INDUSTRY HARDWARE
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MORRIS GERSHANOV		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA EPSTEIN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-16-1091		17. INFORMANT ESTHER GERSHANOV, ADDRESS 9801 INTERLACHEN DR. SILVER SPRING, MARYLAND	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Pulmonary</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 h
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u>		14 mo
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/23/87 to 12/24/87, that (I) (we) lost the deceased alive on 12/23/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EDGAR H. LEVIN, M. D.		22c. ADDRESS 9801 GEORGIA AVENUE SILVER SPRING, MARYLAND		22d. DATE SIGNED 12/24/87	

23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE 12/27/1987	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN	23d. LOCATION FALLS CHURCH VIRGINIA
24a. NAME OF FUNERAL HOME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME		24b. ADDRESS 232 CARROLL STREET N W WASHINGTON, D. C.	25a. DATE REC'D. BY REGISTRAR DEC 29 1987
25b. REGISTRAR'S SIGNATURE John D. Rindler			

2011

THE UNIVERSITY OF CHICAGO

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. DECEASED NAME (TYPE OR PRINT) LEONARDO GIANNESCHI		2a. DATE OF DEATH MONTH DAY YEAR 12 10 87		2b. HOUR 6:45 M	
3. SEX MALE	4. RACE CAUC.	5. DATE OF BIRTH MONTH DAY YEAR 4 03 92		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Stone Mason
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Celestino Gianneschi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Iacopina Simonetti			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO 579-03-2078		17. INFORMANT Anne Mischou-daughter- (same as 13e)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RENAL FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF BLADDER</u> DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> 19 <u>87</u> , to <u>Dec 10</u> 19 <u>87</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>Dec 10</u> 19 <u>87</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> <u>(did not)</u> view the body after death.					
22b. SIGNATURE <u>Bernard A. Fitzgerald</u>		DEGREE MD		22c. DATE SIGNED 12-11-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD		22e. ADDRESS 217 University Blvd E, Silver Spring, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.		23e. DATE REC'D BY REGISTRAR DEC 15 1987			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave., Silver Spring, Md.		25. REGISTRAR'S SIGNATURE <u>John Darden Spindel</u>	

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36194

1. STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3. DATE KNOWN OF DEATH		4. MONTH		5. DAY		6. YEAR		7. HOUR		8. MIN	
		Robert		Giles						Dec 31		19		87							
9. SEX		10. RACE		11. DATE OF BIRTH		12. AGE (IN YEARS LAST BIRTHDAY)		13. IF UNDER 1 YR.		14. IF UNDER 24 HRS.		15. DATE PRONOUNCED DEAD		16. MONTH		17. DAY		18. YEAR		19. HOUR	
M		BLK		Dec 21		29		58		YRS.		MONTHS		DAYS		HOURS		MIN			
20. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		21. CITIZEN OF WHAT COUNTRY?		22. MARRIED		23. NEVER MARRIED		24. WIDOWED		25. DIVORCED		26. BALTIMORE CITY OR COUNTY OF DEATH		27. MONTH		28. DAY		29. YEAR		30. HOUR	
47 WASH. D.C.		USA		YES		NO		YES		NO		MD		Dec 31		19		87		100	
31. CITY OR TOWN OF DEATH		32. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		33. USUAL OCCUPATION (IF MOST OF WORKING LIFE)		34. KIND OF BUSINESS		35. STATE		36. COUNTY		37. CITY OR TOWN		38. INSIDE CITY LIMITS?		39. STREET ADDRESS		40. ZIP CODE		41. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Sil. Spz		Holy Cross Hosp		SELF EMPLOYED		UNK		MD		Monte		Sil. Spz		YES		3111 Medway St		20902			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. SOCIAL SECURITY NO.		18. INFORMANT		19. ADDRESS		20. DATE OF DEATH		21. MONTH		22. DAY		23. YEAR		24. HOUR	
John		Unk.		YES		577-36-3206		Mrs. Doris Jean George Giles, wife				Dec 31		19		87					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I DEATH WAS CAUSED BY:		20. IMMEDIATE CAUSE (a)		21. DUE TO, OR AS A CONSEQUENCE OF		22. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.		23. (b)		24. DUE TO, OR AS A CONSEQUENCE OF		25. (c)		26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
Same as 13e		Acute Myocardial Dis.																None		None	
29. DATE OF OPERATION		30. CONDITION FOR WHICH OPERATION WAS PERFORMED?		31. AUTOPSY?		32. YES		33. NO		34. 21a. EXTERNAL CAUSE WAS		35. 21b. TIME OF INJURY		36. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		37. 21d. INJURY OCCURRED		38. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		39. 21f. LOCATION	
None				YES		NO		NO		UNDERLYING CAUSE OF DEATH		P.M.		19		WHILE AT WORK		STREET, FACTORY, FARM, ETC.)		CITY OR TOWN	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
22a. I certify that I took charge of the remains described above, held on		Autopsy		Inspection		Inquiry		and in my opinion		death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner	
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MADE IN U.S.A.



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1001. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6195	
1- STATE REGISTRAR										7- DATE KNOWN OF ESTI- MATED	
2- DECEASED NAME (TYPE OR PRINT) <i>CLARK</i>										8- MONTH DAY YEAR	
3- SEX <i>F.</i>										9- DATE PRONOUNCED DEAD	
4- RACE <i>W.</i>										10- MONTH DAY YEAR	
5- DATE OF BIRTH (MONTH DAY YEAR) <i>June 10, 1939</i>										11- 19 87	
6- AGE (IN YEARS) (LAST BIRTHDAY) <i>48</i>										12- MONTH DAY YEAR	
7a- BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>LA.</i>										13- MONTH DAY YEAR	
7b- CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>										14- MONTH DAY YEAR	
8- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										15- MONTH DAY YEAR	
9- BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>										16- MONTH DAY YEAR	
10- CITY OR TOWN OF DEATH <i>Silago</i>										17- MONTH DAY YEAR	
11- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Garnage Hill N.H.</i>										18- MONTH DAY YEAR	
12a- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>CLERICAL</i>										19- MONTH DAY YEAR	
12b- KIND OF BUSINESS OR INDUSTRY <i>CATHOLIC</i>										20- MONTH DAY YEAR	
13a- USUAL RESIDENCE (IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) (STATE) <i>DC.</i>										21- MONTH DAY YEAR	
13b- COUNTY <i>Washington</i>										22- MONTH DAY YEAR	
13c- INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										23- MONTH DAY YEAR	
13d- STREET ADDRESS <i>5001 Conn Ave N.W. Apt.</i>										24- MONTH DAY YEAR	
14- FATHER'S NAME (FIRST MIDDLE LAST) <i>JOHN BARRETT</i>										25- MONTH DAY YEAR	
15- MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>EARNEST FLEMING</i>										26- MONTH DAY YEAR	
16a- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>										27- MONTH DAY YEAR	
16b- SOCIAL SECURITY NO. <i>577-40-9513</i>										28- MONTH DAY YEAR	
17- INFORMANT ADDRESS <i>DAUGHTER - MARY L. KNAM SAME AS #13</i>										29- MONTH DAY YEAR	
18- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Chronic Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>Fracture Rt. Hip</i>											
19a- DATE OF OPERATION <i>8-26-87</i>										20- AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19b- CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture Rt. Hip</i>											
21a- EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH										22- TIME OF INJURY HOUR AM MONTH DAY YEAR <i>8:25 PM 8-26-87</i>	
21b- INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK										23- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell at Home</i>	
21c- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>										24- LOCATION CITY OR TOWN COUNTY STATE <i>Conn Ave NW Wash DC</i>	
21d- I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John D. Rogers, M.D.</i> TITLE (SPECIFY) <i>MD</i> MEDICAL EXAMINER										DATE SIGNED <i>Dec 11 1987</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>John D. Rogers</i> ADDRESS											
23a- BURIAL, CREMATION, REMOVAL <i>Burial</i>										23b- DATE <i>Dec 14, 1987</i>	
23c- NAME OF CEMETERY OR CREMATORY <i>HIGHLAND CEM.</i>										23d- LOCATION CITY OR TOWN COUNTY STATE <i>MANSFIELD LA</i>	
24- FUNERAL DIRECTOR <i>DEVON FUNERAL HOME</i>										25- DATE REC'D. BY REGISTRAR <i>DEC 21 1987</i>	
25a- ADDRESS <i>WASHINGTON, D.C.</i>										25b- REGISTRAR'S SIGNATURE <i>John D. Rogers</i>	

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FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36196

1. DECEASED NAME (TYPE OR PRINT) JOSEPH WARREN GOLD			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 29, 1987		2b. HOUR 3:16 AM
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 3, 1957		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY, MD.	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CLINICAL CENTER (NIH)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Business Exec.		12b. KIND OF BUSINESS OR INDUSTRY HECHT CO. Store
13a. STATE DISTRICT OF COLUMBIA			13b. CITY OR TOWN WASHINGTON	13c. STREET ADDRESS / ZIP CODE 1725 WILLARD ST. NW 20009	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL M. GOLD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CHARLOTTE WORTH		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 136-40-7001		17. INFORMANT ADDRESS 56 Old Orchard La. Wayside, NJ	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CNS TOXOPLASMOSES DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins. mins.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from SEPTEMBER 23, 1987 , to DEC. 29, 1987 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on DEC. 29, 1987 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE Edward Chu				22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD CHU				22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20892	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/87		23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodbridge, New Jersey		24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Md. 20852			
25a. DATE REC'D. BY REGISTRAR JAN 4 1988				25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36197

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNIE F. GOLDMAN			2a. DATE OF DEATH MONTH DAY YEAR December 26, 1987		2b. HOUR 6:35 p.m.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Dec. 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 019-26-5203		17. INFORMANT ADDRESS Silver Spring, Md. Edith Robins; Daughter; 9619 Lawndale Drive;	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 83 to 12-26 , 19 87 , that (I) (we) lost saw the deceased alive on 12-9 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Donald L Bucy		DEGREE MD		22c. DATE SIGNED 12-27-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald L Bucy / FRAUKE WESTPHAL		22e. ADDRESS 809 Wicks Mill Rd Rockville Md 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY Sharon Mem. Park	
23d. LOCATION (CITY OR TOWN COUNTY STATE) Boston, Massachusetts		24. FUNERAL DIRECTOR NAME ADDRESS DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852			
25a. DATE REC'D. BY REGISTRAR DEC 29 1987		25b. REGISTRAR'S SIGNATURE [Signature]			

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075191 DEC 16 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY, TOWN, COUNTY, STATE)
Burial	12/9/1987	Judean Memorial Gardens	Olney, Montgomery, Md.
24. DONOR OF ORGAN		25a. DATE REC'D. BY REGISTRAR	
DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		DEC 11 1987	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
		Julia Gordon-Randall	

1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 36198											
2. DECEASED NAME (LAST OR PRINT) FIRST MIDDLE LAST								7a. DATE KNOWN OF DEATH ESTI- MATED				2b. HOUR							
Dorothy Goldstein								X 12 7 19 87				M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		Nov. 24, 1918		69 YRS.		MONTHS		DAYS		12 7 19 87		6:38a M					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
England				U. S. A.								Montgomery County MD							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring				Holy Cross Hospital				Housewife				Own Home							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
Maryland				Montgomery				Silver Spring				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				15300 Beaverbrook Court 20906			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST				FIRST MIDDLE LAST															
Solomon Cowen				Sarah Isaacs															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
No				213-56-9991				David E. Goldstein				9940 Centerway Road, Gaithersburg, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
7 8/20 IMMEDIATE CAUSE (a). Multiple injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				5:55xx 12 7 1987				Driver in auto/auto impact											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)											
				street				Georgia Ave & Forest Glen Rd, Silver Spring, Mont MD											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED											
Mario F. Golle, Jr.				Assistant				MEDICAL EXAMINER				12/7/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS															
Mario F. Golle, Jr., M.D.				111 Penn St.				Balto.MD.											

07/B4
25AA

BP

DHMH - 17
(VR A15 ME (5))

1010

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1010

075280 DEC 15 1987

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 36199

FOR
1- STATE
REGISTRAR

DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Joseph

A.

Goldstein

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

April 30, 1917

70

6. AGE (IN YEARS)

LAST YEAR DAY

MONTHS DAYS HOURS MIN

IF UNDER 1 YR. IF UNDER 24 HRS.

7a. DATE KNOWN
OF DEATHESTI-
MATED

MONTH

DAY

YEAR

2b. HOUR

12

7

19

87

M

7c. DATE
PRONOUNCED
DEAD

12

7

19

87

6AM

M

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Washington, D. C.

7b. CITIZEN OF WHAT COUNTRY?

U. S. A.

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery County

MD

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)Installations
Officer12b. KIND OF BUSINESS
OR INDUSTRY

U.S. Gov't

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Montgomery

13c. CITY OR TOWN

Silver Spring

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

15300 Beaverbrook Court 20906

14. FATHER'S NAME

FIRST

Abe

MIDDLE

M.

LAST

Goldstein

15. MOTHER'S MAIDEN NAME

FIRST

Lena

MIDDLE

Miller

LAST

Miller

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO OR UNKNOWN)

Yes

16b. SOCIAL SECURITY NO.

(IF YES, GIVE NUMBER OR DATES)

WWW 2

16c. SOCIAL SECURITY NO.

578-38-5992

17. INFORMANT

David E. Goldstein

9140 Centerway Road,

Gaithersburg, Md. 20879

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a). Multiple injuries

8121
Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR
5:55 AM 12 7 1987

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

Passenger in auto/auto impact

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

road

21f. LOCATION

STREET CITY OR TOWN COUNTY STATE
Georgia Ave & Forest Glen Rd, Silver Spring, Mont MD

22a. I certify that I took charge of the remains described above, held on

Autopsy ☒Inspection ☐Inquiry ☐

and in my opinion

death resulted from:

Natural causes ☐Accident ☒Suicide ☐Homicide ☐Undetermined manner ☐ACTUAL
SIGNATURE

Mario F. Golle, Jr.

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE SIGNED

12/7/87

EXAMINER'S NAME
(TYPE OR PRINT)

Mario F. Golle, Jr., M.D.

ADDRESS

111 Penn St.

Balto., DM.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

12/9/1987

23c. NAME OF CEMETERY OR CREMATORY

Judean Memorial Gardens

23d. LOCATION
(CITY OR TOWN)

Olney, Montgomery, Md.

STATE

24. DONOR DIRECTOR STEIN HEBREW MEMORIAL FUNERAL HOME

232 CARROLL STREET, N. W., WASHINGTON, D. C.

25a. DATE REC'D. BY REGISTRAR

DEC 11 1987

25b. REGISTRAR'S SIGNATURE

Julia Davidson-Pudney

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE ASSURED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE LOCAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 3, 3A, 3B, 3C, 3D, 3E, 3F, 3G, 3H, 3I, 3J, 3K, 3L, 3M, 3N, 3O, 3P, 3Q, 3R, 3S, 3T, 3U, 3V, 3W, 3X, 3Y, 3Z, 3AA, 3AB, 3AC, 3AD, 3AE, 3AF, 3AG, 3AH, 3AI, 3AJ, 3AK, 3AL, 3AM, 3AN, 3AO, 3AP, 3AQ, 3AR, 3AS, 3AT, 3AU, 3AV, 3AW, 3AX, 3AY, 3AZ, 3BA, 3BB, 3BC, 3BD, 3BE, 3BF, 3BG, 3BH, 3BI, 3BJ, 3BK, 3BL, 3BM, 3BN, 3BO, 3BP, 3BQ, 3BR, 3BS, 3BT, 3BU, 3BV, 3BW, 3BX, 3BY, 3BZ, 3CA, 3CB, 3CC, 3CD, 3CE, 3CF, 3CG, 3CH, 3CI, 3CJ, 3CK, 3CL, 3CM, 3CN, 3CO, 3CP, 3CQ, 3CCR, 3CS, 3CT, 3CU, 3CV, 3CW, 3CX, 3CY, 3CZ, 3DA, 3DB, 3DC, 3DD, 3DE, 3DF, 3DG, 3DH, 3DI, 3DJ, 3DK, 3DL, 3DM, 3DN, 3DO, 3DP, 3DQ, 3DR, 3DS, 3DT, 3DU, 3DV, 3DW, 3DX, 3DY, 3DZ, 3EA, 3EB, 3EC, 3ED, 3EE, 3EF, 3EG, 3EH, 3EI, 3EJ, 3EK, 3EL, 3EM, 3EN, 3EO, 3EP, 3EQ, 3ER, 3ES, 3ET, 3EU, 3EV, 3EW, 3EX, 3EY, 3EZ, 3FA, 3FB, 3FC, 3FD, 3FE, 3FF, 3FG, 3FH, 3FI, 3FJ, 3FK, 3FL, 3FM, 3FN, 3FO, 3FP, 3FQ, 3FR, 3FS, 3FT, 3FU, 3FV, 3FW, 3FX, 3FY, 3FZ, 3GA, 3GB, 3GC, 3GD, 3GE, 3GF, 3GG, 3GH, 3GI, 3GJ, 3GK, 3GL, 3GM, 3GN, 3GO, 3GP, 3GQ, 3GR, 3GS, 3GT, 3GU, 3GV, 3GW, 3GX, 3GY, 3GZ, 3HA, 3HB, 3HC, 3HD, 3HE, 3HF, 3HG, 3HH, 3HI, 3HJ, 3HK, 3HL, 3HM, 3HN, 3HO, 3HP, 3HQ, 3HR, 3HS, 3HT, 3HU, 3HV, 3HW, 3HX, 3HY, 3HZ, 3IA, 3IB, 3IC, 3ID, 3IE, 3IF, 3IG, 3IH, 3II, 3IJ, 3IK, 3IL, 3IM, 3IN, 3IO, 3IP, 3IQ, 3IR, 3IS, 3IT, 3IU, 3IV, 3IW, 3IX, 3IY, 3IZ, 3JA, 3JB, 3JC, 3JD, 3JE, 3JF, 3JG, 3JH, 3JI, 3JJ, 3JK, 3JL, 3JM, 3JN, 3JO, 3JP, 3JQ, 3JR, 3JS, 3JT, 3JU, 3JV, 3JW, 3JX, 3JY, 3JZ, 3KA, 3KB, 3KC, 3KD, 3KE, 3KF, 3KG, 3KH, 3KI, 3KJ, 3KK, 3KL, 3KM, 3KN, 3KO, 3KP, 3KQ, 3KR, 3KS, 3KT, 3KU, 3KV, 3KW, 3KX, 3KY, 3KZ, 3LA, 3LB, 3LC, 3LD, 3LE, 3LF, 3LG, 3LH, 3LI, 3LJ, 3LK, 3LL, 3LM, 3LN, 3LO, 3LP, 3LQ, 3LR, 3LS, 3LT, 3LU, 3LV, 3LW, 3LX, 3LY, 3LZ, 3MA, 3MB, 3MC, 3MD, 3ME, 3MF, 3MG, 3MH, 3MI, 3MJ, 3MK, 3ML, 3MM, 3MN, 3MO, 3MP, 3MQ, 3MR, 3MS, 3MT, 3MU, 3MV, 3MW, 3MX, 3MY, 3MZ, 3NA, 3NB, 3NC, 3ND, 3NE, 3NF, 3NG, 3NH, 3NI, 3NJ, 3NK, 3NL, 3NM, 3NN, 3NO, 3NP, 3NQ, 3NR, 3NS, 3NT, 3NU, 3NV, 3NW, 3NX, 3NY, 3NZ, 3OA, 3OB, 3OC, 3OD, 3OE, 3OF, 3OG, 3OH, 3OI, 3OJ, 3OK, 3OL, 3OM, 3ON, 3OO, 3OP, 3OQ, 3OR, 3OS, 3OT, 3OU, 3OV, 3OW, 3OX, 3OY, 3OZ, 3PA, 3PB, 3PC, 3PD, 3PE, 3PF, 3PG, 3PH, 3PI, 3PJ, 3PK, 3PL, 3PM, 3PN, 3PO, 3PP, 3PQ, 3PR, 3PS, 3PT, 3PU, 3PV, 3PW, 3PX, 3PY, 3PZ, 3QA, 3QB, 3QC, 3QD, 3QE, 3QF, 3QG, 3QH, 3QI, 3QJ, 3QK, 3QL, 3QM, 3QN, 3QO, 3QP, 3QQ, 3QR, 3QS, 3QT, 3QU, 3QV, 3QW, 3QX, 3QY, 3QZ, 3RA, 3RB, 3RC, 3RD, 3RE, 3RF, 3RG, 3RH, 3RI, 3RJ, 3RK, 3RL, 3RM, 3RN, 3RO, 3RP, 3RQ, 3RR, 3RS, 3RT, 3RU, 3RV, 3RW, 3RX, 3RY, 3RZ, 3SA, 3SB, 3SC, 3SD, 3SE, 3SF, 3SG, 3SH, 3SI, 3SJ, 3SK, 3SL, 3SM, 3SN, 3SO, 3SP, 3SQ, 3SR, 3SS, 3ST, 3SU, 3SV, 3SW, 3SX, 3SY, 3SZ, 3TA, 3TB, 3TC, 3TD, 3TE, 3TF, 3TG, 3TH, 3TI, 3TJ, 3TK, 3TL, 3TM, 3TN, 3TO, 3TP, 3TQ, 3TR, 3TS, 3TT, 3TU, 3TV, 3TW, 3TX, 3TY, 3TZ, 3UA, 3UB, 3UC, 3UD, 3UE, 3UF, 3UG, 3UH, 3UI, 3UJ, 3UK, 3UL, 3UM, 3UN, 3UO, 3UP, 3UQ, 3UR, 3US, 3UT, 3UU, 3UV, 3UW, 3UX, 3UY, 3UZ, 3VA, 3VB, 3VC, 3VD, 3VE, 3VF, 3VG, 3VH, 3VI, 3VJ, 3VK, 3VL, 3VM, 3VN, 3VO, 3VP, 3VQ, 3VR, 3VS, 3VT, 3VU, 3VV, 3VW, 3VX, 3VY, 3VZ, 3WA, 3WB, 3WC, 3WD, 3WE, 3WF, 3WG, 3WH, 3WI, 3WJ, 3WK, 3WL, 3WM, 3WN, 3WO, 3WP, 3WQ, 3WR, 3WS, 3WT, 3WU, 3WV, 3WW, 3WX, 3WY, 3WZ, 3XA, 3XB, 3XC, 3XD, 3XE, 3XF, 3XG, 3XH, 3XI, 3XJ, 3XK, 3XL, 3XM, 3XN, 3XO, 3XP, 3XQ, 3XR, 3XS, 3XT, 3XU, 3XV, 3XW, 3XX, 3XY, 3XZ, 3YA, 3YB, 3YC, 3YD, 3YE, 3YF, 3YG, 3YH, 3YI, 3YJ, 3YK, 3YL, 3YM, 3YN, 3YO, 3YP, 3YQ, 3YR, 3YS, 3YT, 3YU, 3YV, 3YW, 3YX, 3YY, 3YZ, 3ZA, 3ZB, 3ZC, 3ZD, 3ZE, 3ZF, 3ZG, 3ZH, 3ZI, 3ZJ, 3ZK, 3ZL, 3ZM, 3ZN, 3ZO, 3ZP, 3ZQ, 3ZR, 3ZS, 3ZT, 3ZU, 3ZV, 3ZW, 3ZX, 3ZY, 3ZZ, 3AA, 3AB, 3AC, 3AD, 3AE, 3AF, 3AG, 3AH, 3AI, 3AJ, 3AK, 3AL, 3AM, 3AN, 3AO, 3AP, 3AQ, 3AR, 3AS, 3AT, 3AU, 3AV, 3AW, 3AX, 3AY, 3AZ, 3BA, 3BB, 3BC, 3BD, 3BE, 3BF, 3BG, 3BH, 3BI, 3BJ, 3BK, 3BL, 3BM, 3BN, 3BO, 3BP, 3BQ, 3BR, 3BS, 3BT, 3BU, 3BV, 3BW, 3BX, 3BY, 3BZ, 3CA, 3CB, 3CC, 3CD, 3CE, 3CF, 3CG, 3CH, 3CI, 3CJ, 3CK, 3CL, 3CM, 3CN, 3CO, 3CP, 3CQ, 3CR, 3CS, 3CT, 3CU, 3CV, 3CW, 3CX, 3CY, 3CZ, 3DA, 3DB, 3DC, 3DD, 3DE, 3DF, 3DG, 3DH, 3DI, 3DJ, 3DK, 3DL, 3DM, 3DN, 3DO, 3DP, 3DQ, 3DR, 3DS, 3DT, 3DU, 3DV, 3DW, 3DX, 3DY, 3DZ, 3EA, 3EB, 3EC, 3ED, 3EE, 3EF, 3EG, 3EH, 3EI, 3EJ, 3EK, 3EL, 3EM, 3EN, 3EO, 3EP, 3EQ, 3ER, 3ES, 3ET, 3EU, 3EV, 3EW, 3EX, 3EY, 3EZ, 3FA, 3FB, 3FC, 3FD, 3FE, 3FF, 3FG, 3FH, 3FI, 3FJ, 3FK, 3FL, 3FM, 3FN, 3FO, 3FP, 3FQ, 3FR, 3FS, 3FT, 3FU, 3FV, 3FW, 3FX, 3FY, 3FZ, 3GA, 3GB, 3GC, 3GD, 3GE, 3GF, 3GG, 3GH, 3GI, 3GJ, 3GK, 3GL, 3GM, 3GN, 3GO, 3GP, 3GQ, 3GR, 3GS, 3GT, 3GU, 3GV, 3GW, 3GX, 3GY, 3GZ, 3HA, 3HB, 3HC, 3HD, 3HE, 3HF, 3HG, 3HH, 3HI, 3HJ, 3HK, 3HL, 3HM, 3HN, 3HO, 3HP, 3HQ, 3HR, 3HS, 3HT, 3HU, 3HV, 3HW, 3HX, 3HY, 3HZ, 3IA, 3IB, 3IC, 3ID, 3IE, 3IF, 3IG, 3IH, 3II, 3IJ, 3IK, 3IL, 3IM, 3IN, 3IO, 3IP, 3IQ, 3IR, 3IS, 3IT, 3IU, 3IV, 3IW, 3IX, 3IY, 3IZ, 3JA, 3JB, 3JC, 3JD, 3JE, 3JF, 3JG, 3JH, 3JI, 3JJ, 3JK, 3JL, 3JM, 3JN, 3JO, 3JP, 3JQ, 3JR, 3JS, 3JT, 3JU, 3JV, 3JW, 3JX, 3JY, 3JZ, 3KA, 3KB, 3KC, 3KD, 3KE, 3KF, 3KG, 3KH, 3KI, 3KJ, 3KK, 3KL, 3KM, 3KN, 3KO, 3KP, 3KQ, 3KR, 3KS, 3KT, 3KU, 3KV, 3KW, 3KX, 3KY, 3KZ, 3LA, 3LB, 3LC, 3LD, 3LE, 3LF, 3LG, 3LH, 3LI, 3LJ, 3LK, 3LM, 3LN, 3LO, 3LP, 3LQ, 3LR, 3LS, 3LT, 3LU, 3LV, 3LW, 3LX, 3LY, 3LZ, 3MA, 3MB, 3MC, 3MD, 3ME, 3MF, 3MG, 3MH, 3MI, 3MJ, 3MK, 3ML, 3MM, 3MN, 3MO, 3MP, 3MQ, 3MR, 3MS, 3MT, 3MU, 3MV, 3MW, 3MX, 3MY, 3MZ, 3NA, 3NB, 3NC, 3ND, 3NE, 3NF, 3NG, 3NH, 3NI, 3NJ, 3NK, 3NL, 3NM, 3NN, 3NO, 3NP, 3NQ, 3NR, 3NS, 3NT, 3NU, 3NV, 3NW, 3NX, 3NY, 3NZ, 3OA, 3OB, 3OC, 3OD, 3OE, 3OF, 3OG, 3OH, 3OI, 3OJ, 3OK, 3OL, 3OM, 3ON, 3OO, 3OP, 3OQ, 3OR, 3OS, 3OT, 3OU, 3OV, 3OW, 3OX, 3OY, 3OZ, 3PA, 3PB, 3PC, 3PD, 3PE, 3PF, 3PG, 3PH, 3PI, 3PJ, 3PK, 3PL, 3PM, 3PN, 3PO, 3PP, 3PQ, 3PR, 3PS, 3PT, 3PU, 3PV, 3PW, 3PX, 3PY, 3PZ, 3QA, 3QB, 3QC, 3QD, 3QE, 3QF, 3QG, 3QH, 3QI, 3QJ, 3QK, 3QL, 3QM, 3QN, 3QO, 3QP, 3QQ, 3QR, 3QS, 3QT, 3QU, 3QV, 3QW, 3QX, 3QY, 3QZ, 3RA, 3RB, 3RC, 3RD, 3RE, 3RF, 3RG, 3RH, 3RI, 3RJ, 3RK, 3RL, 3RM, 3RN, 3RO, 3RP, 3RQ, 3RR, 3RS, 3RT, 3RU, 3RV, 3RW, 3RX, 3RY, 3RZ, 3SA, 3SB, 3SC, 3SD, 3SE, 3SF, 3SG, 3SH, 3SI, 3SJ, 3SK, 3SL, 3SM, 3SN, 3SO, 3SP, 3SQ, 3SR, 3SS, 3ST, 3SU, 3SV, 3SW, 3SX, 3SY, 3SZ, 3TA, 3TB, 3TC, 3TD, 3TE, 3TF, 3TG, 3TH, 3TI, 3TJ, 3TK, 3TL, 3TM, 3TN, 3TO, 3TP, 3TQ, 3TR, 3TS, 3TT, 3TU, 3TV, 3TW, 3TX, 3TY, 3TZ, 3UA, 3UB, 3UC, 3UD, 3UE, 3UF, 3UG, 3UH, 3UI, 3UJ, 3UK, 3UL, 3UM, 3UN, 3UO, 3UP, 3UQ, 3UR, 3US, 3UT, 3UU, 3UV, 3UW, 3UX, 3UY, 3UZ, 3VA, 3VB, 3VC, 3VD, 3VE, 3VF, 3VG, 3VH, 3VI, 3VJ, 3VK, 3VL, 3VM, 3VN, 3VO, 3VP, 3VQ, 3VR, 3VS, 3VT, 3VU, 3VV, 3VW, 3VX, 3VY, 3VZ, 3WA, 3WB, 3WC, 3WD, 3WE, 3WF, 3WG, 3WH, 3WI, 3WJ, 3WK, 3WL, 3WM, 3WN, 3WO, 3WP, 3WQ, 3WR, 3WS, 3WT, 3WU, 3WV, 3WW, 3WX, 3WY, 3WZ, 3XA, 3XB, 3XC, 3XD, 3XE, 3XF, 3XG, 3XH, 3XI, 3XJ, 3XK, 3XL, 3XM, 3XN, 3XO, 3XP, 3XQ, 3XR, 3XS, 3XT, 3XU, 3XV, 3XW, 3XX, 3XY, 3XZ, 3YA, 3YB, 3YC, 3YD, 3YE, 3YF, 3YG, 3YH, 3YI, 3YJ, 3YK, 3YL, 3YM, 3YN, 3YO, 3YP, 3YQ, 3YR, 3YS, 3YT, 3YU, 3YV, 3YW, 3YX, 3YY, 3YZ, 3ZA, 3ZB, 3ZC, 3ZD, 3ZE, 3ZF, 3ZG, 3ZH, 3ZI, 3ZJ, 3ZK, 3ZL, 3ZM, 3ZN, 3ZO, 3ZP, 3ZQ, 3ZR, 3ZS, 3ZT, 3ZU, 3ZV, 3ZW, 3ZX, 3ZY, 3ZZ, 3AA, 3AB, 3AC, 3AD, 3AE, 3AF, 3AG, 3AH, 3AI, 3AJ, 3AK, 3AL, 3AM, 3AN, 3AO, 3AP, 3AQ, 3AR, 3AS, 3AT, 3AU, 3AV, 3AW, 3AX, 3AY, 3AZ, 3BA, 3BB, 3BC, 3BD, 3BE, 3BF, 3BG, 3BH, 3BI, 3BJ, 3BK, 3BL, 3BM, 3BN, 3BO, 3BP, 3BQ, 3BR, 3BS, 3BT, 3BU, 3BV, 3BW, 3BX, 3BY, 3BZ, 3CA, 3CB, 3CC, 3CD, 3CE, 3CF, 3CG, 3CH, 3CI, 3CJ, 3CK, 3CL, 3CM, 3CN, 3CO, 3CP, 3CQ, 3CR, 3CS, 3CT, 3CU, 3CV, 3CW, 3CX, 3CY, 3CZ, 3DA, 3DB, 3DC, 3DD, 3DE, 3DF, 3DG, 3DH, 3DI, 3DJ, 3DK, 3DL, 3DM, 3DN, 3DO, 3DP, 3DQ, 3DR,

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6200

FOR
1- REGISTRAR

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ANNA MARIE GOLDYN					X		12	30	87	PM
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD	2d. HOUR
Female	White	Sept. 12, 1955		32 YRS.					12-30-87	1PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland		U.S.A.		WIDOWED		DIVORCED		Montgomery County		MD
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban Hospital		Financial Analyst-Digital Equip.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
North Carolina		Guilford		Greensboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3507 Darden Rd.		27407
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME								
Michael J. Seta		Mary S. Provenanzno								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
No		213-52-8708		Edward M. Goldyn - same as #13e						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) <u>Adrenal hemorrhages</u>		
DUE TO, OR AS A CONSEQUENCE OF		
(b) <u>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</u>		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE Margarita A. Korell TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 12-31-87
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	1-4-88	Holy Redeemer	Balto.		Md.
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Ruck Towson Funeral Home, Inc., Towson, Md. 21204		1050 York Rd.		JAN 5 1988	<u>John Skidmore</u>

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

FORM 17
(VR 115 ME (5))

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36201

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis J. Gonzalez			2a. DATE OF DEATH MONTH DAY YEAR 12-16-87		2b. HOUR MIN. 5:25 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 06-17-1918		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mexico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Personnel Officer		12b. KIND OF BUSINESS OR INDUSTRY State Dept.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Cleto Gonzalez		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marue Gonzalez		13e. STREET ADDRESS / ZIP CODE 10226 Parkwood Drive		13f. ZIP CODE 20895	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 514-03-4253		17. INFORMANT Catherino Gonzalez		ADDRESS 10226 Parkwood Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) perforated abdominal viscous DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Carcinoma of stomach DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 3 months							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Chronic obstructive lung disease							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from 12/14/87 , 19____, to 12/16/87 , 19____, that (I) (we) last saw the deceased alive on 12/15/87 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jeremy V. Poolce				DEGREE MD		22c. DATE SIGNED 12/16/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jeremy V. Poolce				22e. ADDRESS 10400 Penn. Ave - Kensington			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-23-87		23c. NAME OF CEMETERY OR CREMATORY Georgetown Univ. Med School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC	
24. FUNERAL DIRECTOR NAME Robert G. Mason				ADDRESS 1661 Good Hope Rd, SE		25a. DATE REC'D. BY REGISTRAR DEC 31 1987	
				25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

MEDICAL CERTIFICATION

9-9

IMPORTANT: If item 21 is marked or item 18 shows any injury, other traumatic event, the medical examiner must be notified prior to funeral director.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the deceased remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

7618-5 DEC 28

07- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36202

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST AGNES JEANETTE GRADY			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 22 1987		2b. HOUR P M 6:05 P
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JUNE 3 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RHODE ISLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN BETHESDA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> X	13e. STREET ADDRESS / ZIP CODE 7510 GLENBROOK ROAD 20814	
14. FATHER'S NAME FIRST MIDDLE LAST FRED GEORGE MICHELS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN CECELIA LYNCH			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO -		16b. SOCIAL SECURITY NO. 039-05-9816		17. INFORMANT ADDRESS J. WILLIAM GRADY, 7510 GLENBROOK ROAD, BETHESDA, MD 20814	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) SEVERE PULMONARY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from FEBRUARY 23, 1987 , to DECEMBER 22, 1987 , that (I) (we) lost saw the deceased alive on DECEMBER 22, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. X. Dwyer LTMC MD				22c. DATE SIGNED 23 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. X. DWYER, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE DECEMBER 29, 1987	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VIRGINIA	
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOME/ BETHESDA CHEVY CHASE, INC. 7557 WISCONSIN AVENUE BETHESDA, MARYLAND 20814				25a. DATE REC'D. BY REGISTRAR DEC 24 1987	
				25b. REGISTRAR'S SIGNATURE <i>Julia Anderson-Randall</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

BP _____

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FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36203

1. DECEASED NAME (TYPE OR PRINT) PATRICIA MAHRER GRAHAM			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 13 1987		2b. HOUR 5:03 P_M
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR APRIL 12 1922		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE VIRGINIA		13b. COUNTY LOUDON	13c. CITY OR TOWN STERLING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 120 MEADOWLAND DRIVE 22170
FATHER'S NAME FIRST MIDDLE LAST JOSEPH LOUIS MAHRER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY VIRGINIA HAYWOOD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 221-10-6941		17. INFORMANT ADDRESS CHARLES H. GRAHAM, 120 MEADOWLAND DRIVE,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 25 19 87 , to DECEMBER 13 19 87 , that (I) (we) last saw the deceased alive on DECEMBER 13 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Drew Lewis				22c. DATE SIGNED 14 DEC 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DREW E. LEWIS, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE Dec. 17, 1987	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON, VA.	
24. FUNERAL DIRECTOR NAME ADDRESS J. BERKLEY GREEN 22070		25a. DATE REC'D. BY REGISTRAR DEC 18 1987		25b. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the cause of death must be identified above.

MEDICAL CERTIFICATION

BP 99299
DHMH - 10-60M 7/84
(VRA 15, 4)

75204 DEC 18/81

DEC 18 1981

076239 DEC 28 87

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36204

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph B. Graves Sr.			2a. DATE OF DEATH MONTH DAY YEAR December 20, 1987		2b. HOUR 1:00a M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR September 26, 1913		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 74	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 19413 Brassie Place #103		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dept. Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Dept. of Commerce	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Leo H. Graves, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie E. Morris		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII			
16b. SOCIAL SECURITY NO. 577 48 6376		17. INFORMANT (Wife) Wanda P. Graves		18. ADDRESS Same as line #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden death-cardiac arrhythmia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 6 years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the deceased) attended the deceased from October 25, 1982 to December 20, 1987 that (I) (we) last saw the deceased alive on November 16, 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Richard M. Huffman MD.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/21/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard M. Huffman M.D.		22e. ADDRESS 3301 New Mexico Avenue N.W. Washington D.C. 20016					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring Maryland		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850		25. DATE REC'D. BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal death certificate must be verified by a coroner.

1000

076220 DEC 20 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201. PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 6205	
1- DECEASED NAME (OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR					
Doris		M.		Gray				12/21/87		12		21		19		10:40 AM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR			
Female		Cauc.		Sept. 6, 1917		70 YRS.						12/21/87		12		21		19			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Massachusetts		United States		MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		Montgomery County,									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK)		12b. KIND OF BUSINESS OR INDUSTRY															
Silver Spring		506 Bonifant Street		Executive Secretary		F.B.I.															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		506 Bonifant Street		20910											
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST											
Gerald		Galloway		Gray		Marguerite		King													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS															
No		034-10-9822		John E. Gray		34A Ridge Road		Greenbelt, Maryland		20770											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																					
PART I DEATH WAS CAUSED BY:																					
IMMEDIATE CAUSE (a) Environmental Hyperthermia and																					
Arteriosclerotic Cardiovascular Disease																					
(b) DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?							
														YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
				HOUR AM MONTH DAY YEAR				subject found in overheated house													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION													
				home				506 Bonifant St., Silver Spring, Montg., Md.													
22a. I certify that took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE				TITLE (SPECIFY)										DATE SIGNED							
				Assistant										12/21/87							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																	
Dennis F. Smyth, M.D.				111 Penn St., Balto., Md. 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION									
Burial				Dec. 23, 1987				Gate of Heaven Cemetery				Silver Spring Maryland									
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814				12/24/1987																	

07-84
25M

BP
DHMH - 17
(VR A15 ME (1))

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ONE

WINTER

1912

REPRINT 101100-6005



1912

14849 DEC 11 1987

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6206

1. DECEASED NAME (TYPE OR PRINT) Raymond W. Grayson, Jr.			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>			2b. HOUR 02 ²⁵ M											
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 08 DAY 06 YEAR 32			6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.			7c. DATE PRONOUNCED DEAD MONTH 12 DAY 2 YEAR 1987			7d. HOUR 02 ²⁵ M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.								
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10111 PARKWOOD TR						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Raleigh					
13a. STATE MD			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN BETHESDA			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 20814 10111 PARKWOOD TR					
14. FATHER'S NAME FIRST Raymond MIDDLE W. LAST Grayson, Sr.						15. MOTHER'S MAIDEN NAME FIRST Marion MIDDLE Fribourg											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes.			16b. SOCIAL SECURITY NO. Korean			17. INFORMANT Barbara F. Grayson			17. ADDRESS Same as Item # 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CIRCULATORY DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 12 2 1987				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) COLLAPSED AT HOME									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME				21f. LOCATION STREET 10111 PARKWOOD TR CITY OR TOWN BETHESDA COUNTY MONTGOMERY STATE MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Francis C. Mayle				TITLE (SPECIFY) DEPT MEDICAL EXAMINER						DATE SIGNED 12/2/87							
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle				ADDRESS 8200 Wisconsin Ave Bethesda MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory				23d. LOCATION CITY OR TOWN Alexandria, VA COUNTY STATE							
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016																	

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Raymond, Jr.

Raymond

Indice

Indice

...

Walter

John

Raymond

Raymond

Raymond, Jr.

...

Raymond

Raymond, Jr. Raymond, Jr. Raymond, Jr.

Raymond, Jr.

Raymond

Raymond

U.S. District Court, Alexandria, VA

U.S. District Court, Alexandria, VA

U.S. District Court, Alexandria, VA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36207

1. DECEASED NAME (TYPE OR PRINT) William L Green		2a. DATE OF DEATH MONTH DAY YEAR December 25, 1987		2b. HOUR M AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar 7, 1910	
7a. BIRTHPLACE (COUNTRY) Wash., DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 77 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5503 Burling Court		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY Law Enforcement			
13a. STATE MD		13b. COUNTY Mont.		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST William Thomas Green		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie May Hudson		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-05-5657		17. INFORMANT ADDRESS Marjorie Britt 4923 MA Ave. NW Wash., DC 20016	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOGU DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) METASTATIC CANCER DUE TO, OR AS A CONSEQUENCE OF (c) BRONCH CANCER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 hr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/19 , 19 86 , to 12/25 , 19 87 , that (I) (we) lost saw the deceased alive on 11/10 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Stanley A Schwartz M.D. DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12/25/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stanley A, Schwartz, M.D.			22e. ADDRESS Chevy Chase 20815 5454 WI Ave Bethesda, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/87		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring MD					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016				25a. DATE REC'D. BY REGISTRAR DEC 30 1987	
				25b. REGISTRAR'S SIGNATURE	

078831 100070

December 22, 1987

Green

I

William

36

May 7, 1987

Miss

Miss

Montgomery

x

U.S.A.

Miss, Mr.

5505 Building Court

Bedford

5505 Building Ct. 50817

x

Bedford

Mont.

MD

Hudson

May

Annex

Green

Thomas

William

5000

10000 4525 W. Ave. W. Wash., DC

578-07-587

NO

x

50817

Cherry Chase

2424 W. Ave. Kensington, MD

Stanley A. Schwartz, M.D.

Silver Spring MD

Gate of Heaven Cem

12/25/87

Burial

Joseph Taylor's Home, Inc.
2130 W. Ave. W. Wash., DC 20006

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36208

1. DECEASED NAME (TYPE OR PRINT)		FIRST THOMAS F.		MIDDLE GREENE		LAST GREENE		2a. DATE OF DEATH MONTH DAY YEAR 12-20-87		2b. HOUR 3:48 PM	
3. SEX M		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 31, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE MARYLAND		12b. COUNTY MONTGOMERY		12c. CITY OR TOWN ROCKVILLE		12d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		12e. STREET ADDRESS / ZIP CODE 4806 LISTRA ROAD 20853		12f. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LETTER CARRIER	
13. FATHER'S NAME FIRST MIDDLE LAST THOMAS GREENE		14. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA CURLEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16. SOCIAL SECURITY NO. 072-34-2745		17. INFORMANT ELIZ PARKER/DAUGHTER/SAME AS 13		18. ADDRESS	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute coronary heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>hypertensive cardiovascular disease</i>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>chronic renal failure; sepsis; acute gastrointestinal bleed</i>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from <i>12/19</i> 19 <i>87</i> , to <i>12/20</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>12/19</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22a. SIGNATURE <i>Francine</i>		22b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Wilhelmina G. L. Camara</i>		22e. ADDRESS <i>490 ADRIAN ST Rockville MD 20853</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC 23, 1987		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONTGOMERY MD		24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS, JR. ADDRESS 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901		25. DATE REC'D BY REGISTRAR DEC 24 1987	

MEDICAL CERTIFICATION

DEC 28 1987

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper tags which should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH87 36209
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sadie Grolman		2a. DATE OF DEATH MONTH DAY YEAR 12-12-87		2b. HOUR MIN. 6:55 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 12-14-1893		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK CITY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH ROCKVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HEBREW HOME OF GREATER WASHINGTON		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	13c. CITY OR TOWN ROCKVILLE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 6121 MONTROSE RD. (20852)
14. FATHER'S NAME FIRST MIDDLE LAST DAVID WOLF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BESSIE LEVY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-46-7184	17. INFORMANT DAUGHTER ADDRESS SILVER SPRING, MD VERECE SILVERMAN: 15101 INTERLACHEN DR #418			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest. DUE TO, OR AS A CONSEQUENCE OF (b) Severe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Demented. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk - years.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1-28-1982 , to 12-12-1987 , that (I) (we) last saw the deceased alive on 12-12-1987 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
21g. SIGNATURE LORETO S. ALBIOL, MD		DEGREE		22c. DATE SIGNED 12-12-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LORETO S. ALBIOL, MD		22e. ADDRESS 6121 MONTROSE RD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 12/14/87	23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GDN.		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH FAIRFAX VA.	
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		ADDRESS 1100 ROCKVILLE PK: ROCKVILLE, MD 20852		25a. DATE REC'D. BY REGISTRAR DEC 15 1987	25b. REGISTRAR'S SIGNATURE Julia Benson-Randall

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FOR
STATE
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FIELD

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
HALLMAN CERTIFICATE OF DEATH87 36210
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lois Field Hallman			2a. DATE OF DEATH MONTH DAY YEAR 12-29-87		2b. HOUR 5:30 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 12 05		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CALIFORNIA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH OLNEY	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE Nsg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY US GOV.
13a. STATE MD.		13b. COUNTY Mont.	13c. CITY OR TOWN Laytonsville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7201 Brink Road 20879
14. FATHER'S NAME FIRST MIDDLE LAST FRANK HALLMAN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE FIELD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-44-6833		17. INFORMANT ADDRESS ROBERTA M. DOWNES SAME AS # 13	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Failure DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Hypertensive C.V. Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs 12-24-87 145
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/11/87 to 12/29/87 , that (I) (we) last saw the deceased alive on 12/11/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the body was not seen after death, so state.)					
22b. SIGNATURE C. W. Light				22c. DATE SIGNED 12/29/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. W. Light				22e. ADDRESS 1814 P & Philip Dr. Olney MD 20832	
23a. BURIAL, CREMATION, REMOVAL CREMATION		23b. DATE DEC. 30, 1987		23c. NAME OF CEMETERY OR CREMATORY BALT. WASH. CREMATORY	
24. FUNERAL DIRECTOR NAME MURIEL H. BARBER		ADDRESS LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR JAN 4 1988	
				25b. REGISTRAR'S SIGNATURE John D. Barber	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: Law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1- STATE REGISTRAR									
2- DECEASED NAME (TYPE OR PRINT) Mary MARY C Hamberger HAMBERGER									
3- SEX Fe		4- RACE Cauc		5- DATE OF BIRTH MONTH DAY YEAR 07 22 16		6- AGE (IN YEARS) (LAST BIRTHDAY) 71 YRS.		7- IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	
8- BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		9- CITIZEN OF WHAT COUNTRY? U.S.A.		10- MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11- DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> 12 25 19 87 20 ⁵² M		12- DATE PRONOUNCED DEAD 12 25 19 87 20 ⁵² M	
13- CITY OR TOWN OF DEATH BETHESDA		14- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		15- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		16- KIND OF BUSINESS OR INDUSTRY Home		17- BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
18- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 18a STATE PA 18b COUNTY N 18c CITY OR TOWN SINKING SPRING		19- INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20- STREET ADDRESS 38 PENN. AVE		21- ZIP CODE 99999			
22- FATHER'S NAME Martin MIDDLE Snitzer LAST Theresa MIDDLE Skakandi LAST James		23- MOTHER'S MAIDEN NAME Theresa MIDDLE Skakandi LAST James		24- ADDRESS 4908 Jamestown Rd. Bethesda, Md. 20816		25- 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)		26- 16b SOCIAL SECURITY NO. 165-10-8395	
27- 17. INFORMANT Edward Hamberger		28- ADDRESS 4908 Jamestown Rd. Bethesda, Md. 20816		29- 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION (b) ARTERIOCLEROTIC CARDIOVASCULAR DISEASE (c) ACUTE		30- APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE		31- PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 1a	
32- 19a DATE OF OPERATION		33- 19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		34- 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		35- 21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		36- 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 12 25 19 87	
37- 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AFTER MEAL		38- 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		39- 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		40- 21f LOCATION STREET CITY OR TOWN COUNTY STATE 4908 JAMESTOWN RD BETHESDA MONT MD		41- 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
42- ACTUAL SIGNATURE Francis C. Mayle TITLE (SPECIFY) DEPT M.D. DEPT MEDICAL EXAMINER		43- DATE SIGNED 12/24/87		44- EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle ADDRESS 8200 Wisconsin Ave Bethesda		45- 23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		46- 23b DATE 12-29-1987	
47- 23c NAME OF CEMETERY OR CREMATORY Hain's Church Cemetery		48- 23d LOCATION CITY OR TOWN COUNTY STATE Wernersville Berks Co. Pa.		49- 24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons ADDRESS 5130 Wt. Ave. N.W. Wash. D.C.		50- 25a DATE REC'D. BY REGISTRAR DEC 30 1987		51- 25b REGISTRAR'S SIGNATURE	

BP
DHMH
(VR A15 ME (5))

Joseph Lawler's Bone 5130 Wt. Ave. N.W. Wash.
12-29-1987 Hatn's Church Cemetery Wernersville Berks Co. Pa.

Burial

No

Martin

165-10-8395

Edward Hamberger

Theresa

Snitzer

Okakandi

Homemaker

Home

Is.

U.S.A.

Mary

Hamberger

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

87 36212

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY L. HARDING			2a. DATE OF DEATH MONTH DECEMBER DAY 5 YEAR 1987		2b. HOUR 815 P.M.		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH 2 DAY 22 YEAR 08		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Central Charge	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST Ellwood MIDDLE H. LAST Corberth		15. MOTHER'S MAIDEN NAME FIRST Rosie MIDDLE L. LAST Gise		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-36-5341A	
17. INFORMANT Catherine P. Sessoms		ADDRESS 802 Roxboro Rd. Rockville, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CALCINOMA OF OVARY DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

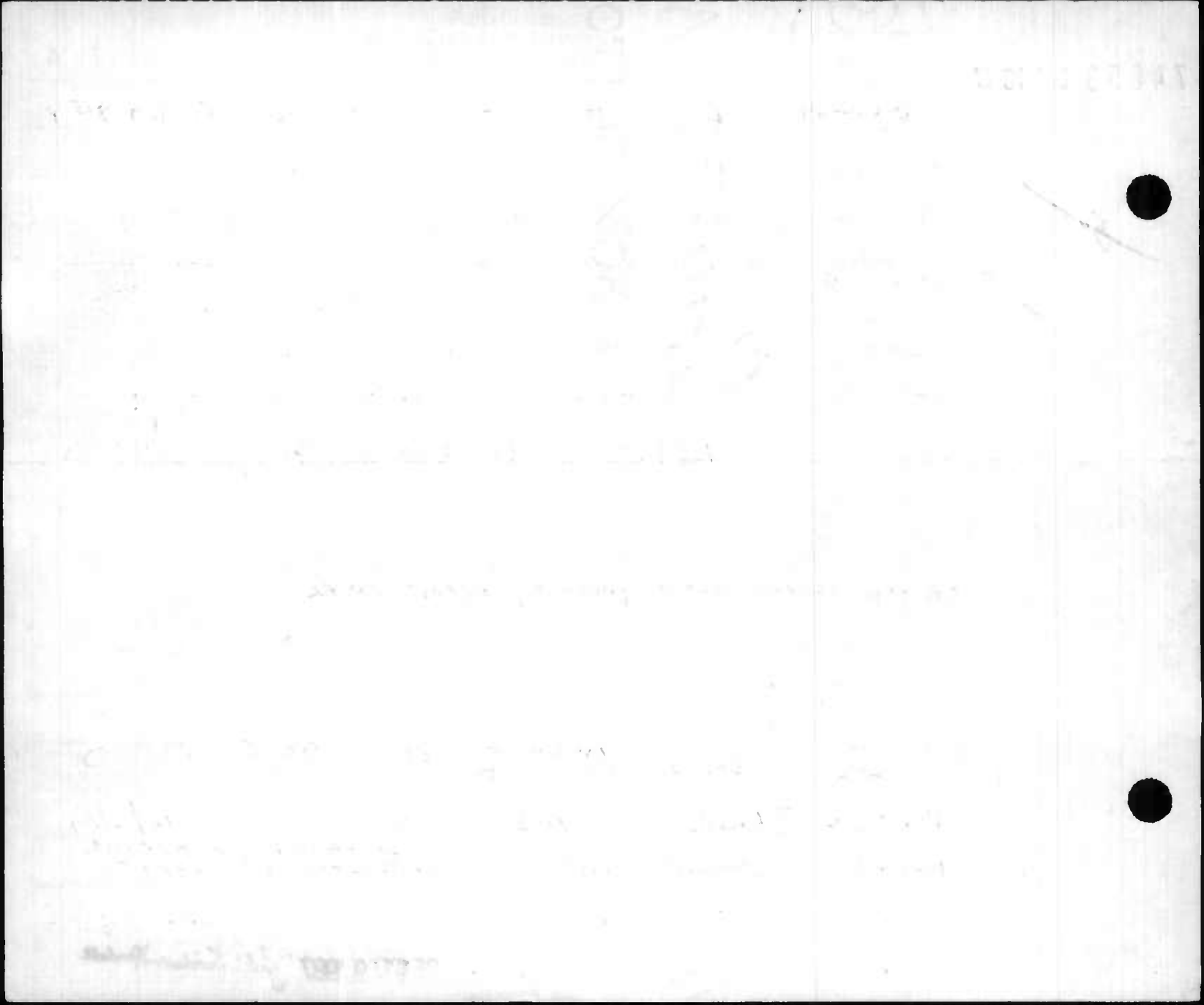
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

CHRONIC ORGANIC BRAIN SYNDROME; BREAST CANCER

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (1) (this hospital) attended the deceased from MARCH 10 , 19 81 , to DEC 5 , 19 87 , that (2) (we) lost saw the deceased alive on Dec 2 , 19 87 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (3) (we) did (did not) view the body after death.							
22b. SIGNATURE Martin C. Shargel				DEGREE M.D.		22c. DATE SIGNED 12/6/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN C. SHARGEL, M.D.				22e. ADDRESS 3720 FARRAGUT AVENUE KENSINGTON, MD - 20895			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME George P. Kalas Funeral Home				ADDRESS 6160 Oxon Hill Rd. Oxon Hill, Md.		25a. DATE REC'D. BY REGISTRAR DEC 09 1987	
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall							



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36213

1. DECEASED NAME (TYPE OR PRINT) CHRISTOS HARMANTAS		2a. DATE OF DEATH MONTH DAY YEAR 12-30-87		2b. HOUR 2308 M
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 10 23 02		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CO. MD.
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meteorologist	12b. KIND OF BUSINESS OR INDUSTRY U.S. Government
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Mont.	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Constantine Hermantas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Stylianos		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 216-44-4190	17. INFORMANT Dena Harmantas, same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: DIABETES MELLITUS, CHRONIC RENAL FAILURE				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from 12/30, 1987, to 12/30, 1987, that (I) (we) last saw the deceased alive on 12/30, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (check) (did not) view the body after death.				
22b. SIGNATURE Alan S. Chanales	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED Dec. 31, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALAN S. CHANALES		22e. ADDRESS 15225 SHADY GROVE RD ROCKVILLE MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Jan. 2, 1988	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.	23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814		25a. DATE REC'D. BY REGISTRAR JAN 4 1988		

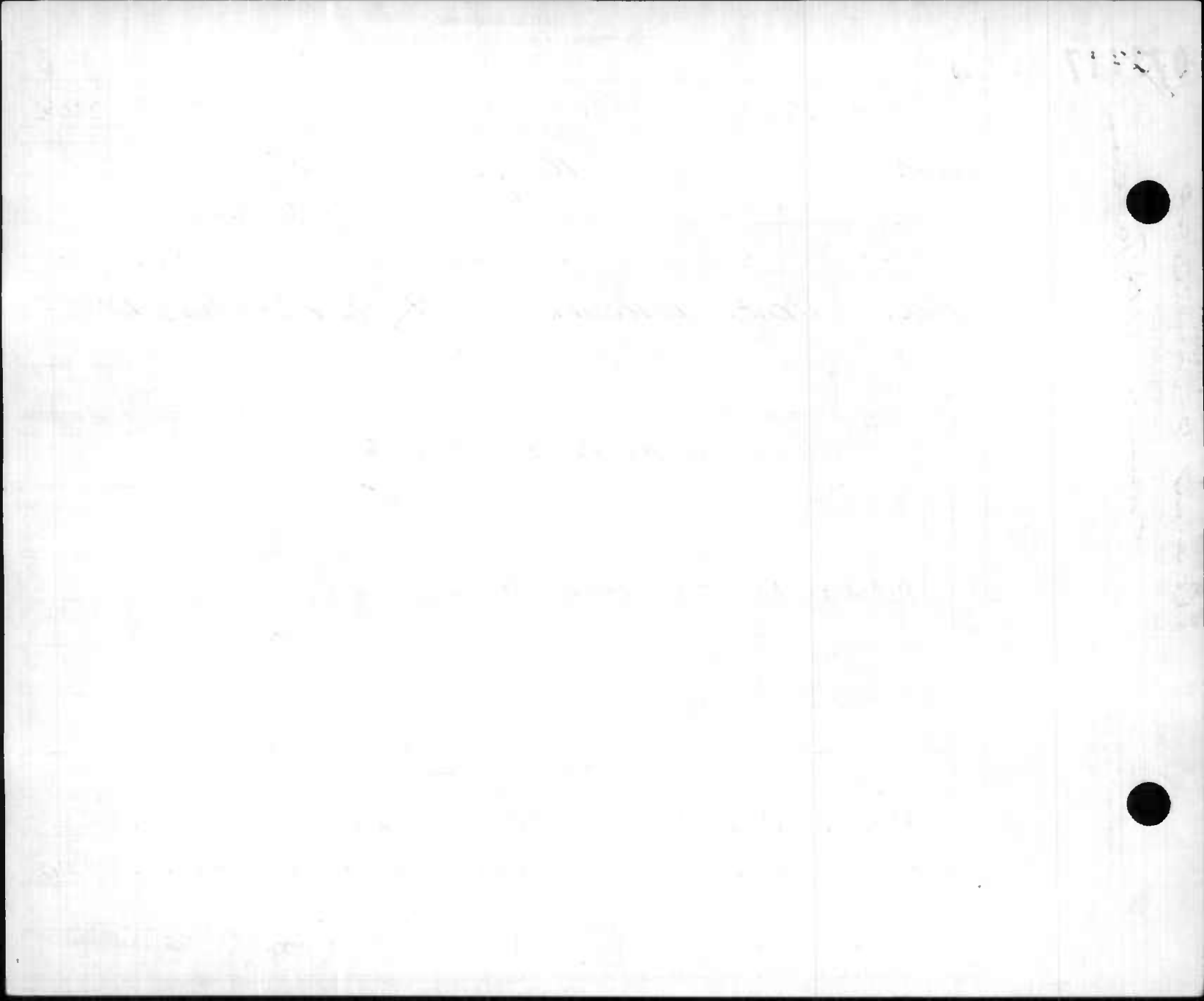
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

BP



075557 DEC 21 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 104.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 36214									
1- FOR STATE REGISTRAR										2a DATE KNOWN OF DEATH		2b HOUR							
2- DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Randy Eugene Harps										MONTH DAY YEAR 12/ 5/ 19 87		M 11:10 a							
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 12 5 64		6 AGE (IN YEARS) (LAST BIRTHDAY) 23 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD MONTH DAY YEAR 12/ 5/ 19 87		2d HOUR 11:10 a					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD							
10 CITY OR TOWN OF DEATH Rockville				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12000 Old Georgetown Rd.						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Active duty				12b KIND OF BUSINESS OR INDUSTRY Military					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a STATE Md		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS BEQ 20814	
14. FATHER'S NAME FIRST MIDDLE LAST Carl E. Harps										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ola Jane Cottrill									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. 553-08-8421				17 INFORMANT Ola Jane Cottrill/ 5 Oregon St Washington				ADDRESS PA							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:49AM 12/ 5/ 19 87				21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject precipitated from building											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) pavillion at				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12000 Old Georgetown Rd., Rockville, Montg., Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 12/6/87							
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal				23b. DATE 12-9-87				23c. NAME OF CEMETERY OR CREMATORY Wm J. Neal Funeral Home				23d. LOCATION CITY OR TOWN COUNTY STATE Washington PA							
24. FUNERAL DIRECTOR NAME Marshall's Funeral Home, Inc.				ADDRESS 4217 9th St., NW Washington, DC 20011				DATE REC'D. BY REGISTRAR DEC 16 1987				REGISTRAR'S SIGNATURE <i>John Dearden</i>							

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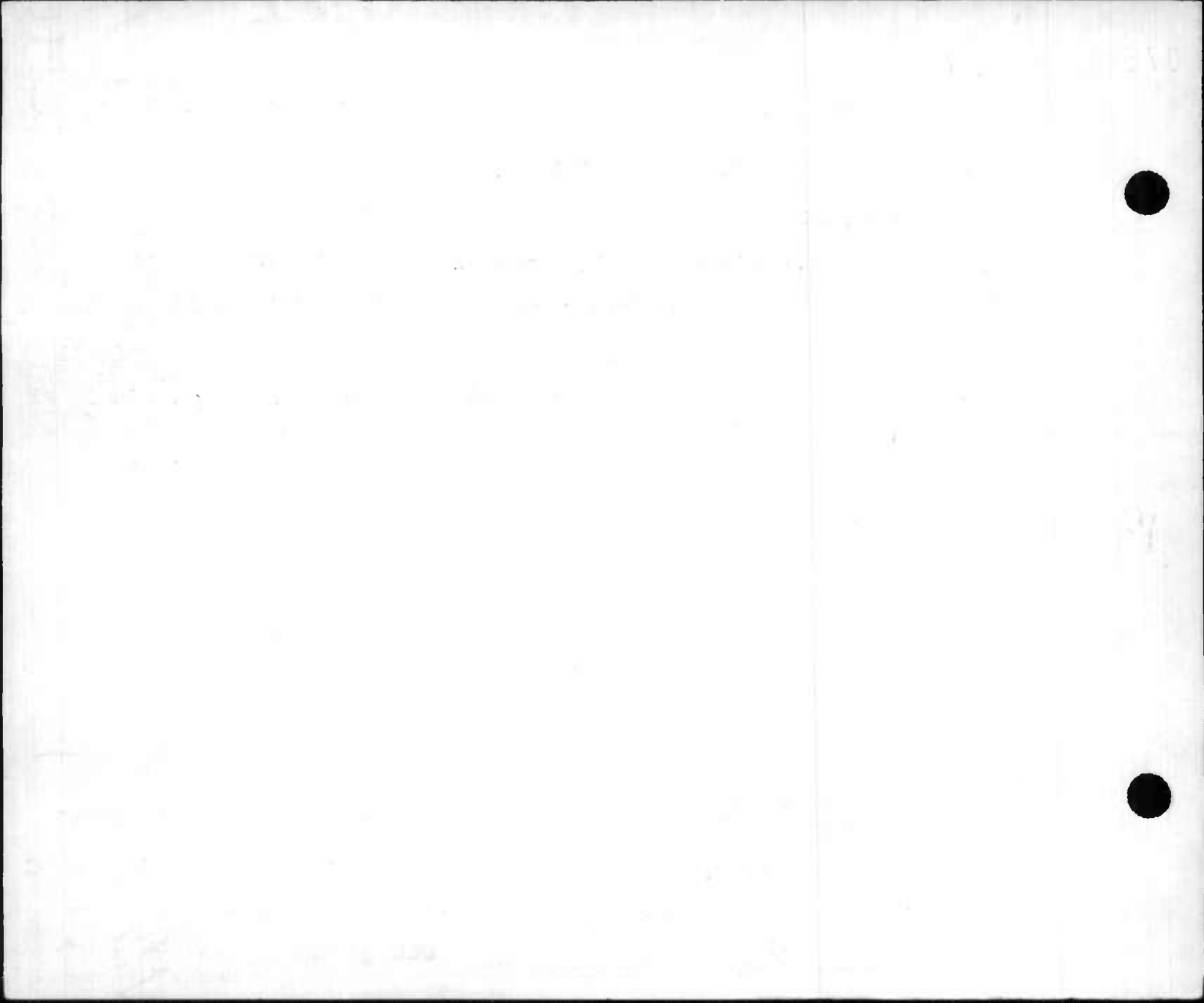
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO. 87 36215	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jeanette V. Harries		2a. DATE OF DEATH MONTH DAY YEAR December 16, 1987	
3. SEX Female		2b. HOUR 12:30 PM	
4. RACE White		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
5. DATE OF BIRTH MONTH DAY YEAR July 27, 1905		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
7b. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary	
10. CITY OR TOWN OF DEATH Takoma Park		12b. KIND OF BUSINESS OR INDUSTRY Pepco	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Heritage Nursing Facility		13a. STREET ADDRESS / ZIP CODE 3004 Gainesville Street SE 99999	
13a. STATE DC		13b. CITY OR TOWN Washington DC	
13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 3004 Gainesville Street SE	
14. FATHER'S NAME FIRST MIDDLE LAST Maddox		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FAirall	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 579-07-7621	
17. INFORMANT Gerald O'Brien		10805 Southwest 132nd Circle Ct, Miami, FL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cordia pulmonary embol</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertensive hemorrhagic cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary atherosclerosis</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 10/22, 1987 to present, 1987, that (I) (continued) saw the deceased alive on 10/9, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Barrett Burka</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22c. DATE SIGNED 12-16-87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Barrett Burka, M.D.	
22e. ADDRESS 4607 Connecticut Ave NW Washington DC		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	
23b. DATE 21 Dec 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va		24. FUNERAL DIRECTOR NAME Robert E Wilhelm	
24b. ADDRESS Suitland, Md		24c. DATE RECEIVED BY REGISTRAR DEC 22 1987	
24d. REGISTRAR'S SIGNATURE <u>J. J. [Signature]</u>			



075209 DEC 15 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 2 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36216

DECEASED NAME (TYPE OR PRINT) BETTINA HARRIS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 9, 1987		2b. HOUR A. 4:15 M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR NOV. 19, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BURTONSVILLE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2901 GREEN CASTLE RD. 20866		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TEACHER	12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE NEW JERSEY	13b. COUNTY	13c. CITY OR TOWN HACKENSACK	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 151 PROSPECT AVE. 07601	
14. FATHER'S NAME FIRST MIDDLE LAST ISAAC MERSHON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JENNIE MIRSK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 118-18-8605	17. INFORMANT SHELLEY ROCHESTER 2901 GREEN CASTLE RD. BURTONSVILLE, MD 20866			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3/87					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION N/A	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) N/A			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> N/A	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A	21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A			
22. I certify that (I) (this hospital) attended the deceased from <u>11/24</u> 19 <u>87</u> to <u>12/9</u> 19 <u>87</u> , that (he) (she) (it) <u>was</u> (was not) <u>alive</u> on <u>12/9</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (they) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>K. S. Kirwin</u>		DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/9/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KATHRYN S. SIENA		22e. ADDRESS KIRWIN MD 10400 Connecticut Ave, Kensington Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL	23b. DATE DEC. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY CEDAR PARK	23d. LOCATION CITY OR TOWN COUNTY STATE PARAMUS NEW JERSEY		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215			25a. DATE REC'D. BY REGISTRAR DEC 15 1987		
			25b. REGISTRAR'S SIGNATURE <u>Julia D. ...</u>		

03-2509 DEC 15 84

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 03-25-09 BY 60322

DEC 15 1984

U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

074943 DEC 13 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DHMH - 16 60M 7/84
(VRA 15, 4)FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDWARD VINCENT HARRIS, JR.			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 4 1987		2b. HOUR 3:20 A M
3 SEX MALE	4 RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JANUARY 30 1926		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED	12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY	
13a. STATE MARYLAND	13b. COUNTY BALTIMORE	13c. CITY OR TOWN BROOKLYN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 505 ARSAN AVENUE 21225	
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD VINCENT HARRIS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HAZEL B. SYKES			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES	16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 1950-1974	17. INFORMANT ADDRESS 21225 EMILIE H. HARRIS, 505 ARSAN AVENUE, BROOKLYN, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NON SMALL CELL CARCINOMA OF THE LUNG</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 2</u> , 19 <u>87</u> , to <u>DECEMBER 4</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>DECEMBER 4</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>N. H. Waker</i>		DEGREE <i>MD</i>		22c. DATE SIGNED 12-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. G. LITAKER, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/9/87	23c. NAME OF CEMETERY OR CREMATORY Cheltenham Veterans Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham (Pr. Geo's) Md.	
24. FUNERAL DIRECTOR Richard A. Coleman Funeral Home		-Upper Marlboro, Md. 20772		25a. DATE REC'D. BY REGISTRAR DEC 14 1987	25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Randall</i>

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

Dr. Richard Whelton was Notified and cleared 12/14/87

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DECEASED NAME FIRST MIDDLE LAST OSWALD Lionel HARVEY		2a. DATE OF DEATH MONTH DAY YEAR 12-13-87		2b. HOUR 454 P.M.		REG. NO. 36218	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR December 2, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH AFRICA		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Statistician		12b. KIND OF BUSINESS OR INDUSTRY Dept of Labor			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Oswald George Harvey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith Kate Mawbey		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No None		16b. SOCIAL SECURITY NO. 216-44-4501		17. INFORMANT ADDRESS Katherine Andrews Harvey Silver Spring Maryland 20901	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOVOLEMIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>MASSIVE BLOOD LOSS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>RUPTURED AORTIC ANEURYSM</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL <u>2 Hours</u> <u>5 Hours</u> <u>7 Hours</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION 12-13-87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED RUPTURED ABDOMINAL AORTIC ANEURYSM		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 12-13, 1987, to 12-13, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did (did not) view the body after death.									
22b. SIGNATURE Garry D. Ruben		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Dec. 14, 1987			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GARRY D. RUBEN, M.D.		22e. ADDRESS 11120 NEW HAMPSHIRE AVE SILVER SPRING, MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Dec. 14, 1987		23c. NAME OF CEMETERY OR CREMATORY Geo. Wash. Medical School		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME 225 Missouri Ave. N.W. Washington D.C.		25. DATE REC'D. BY REGISTRAR DEC 21 1987		26. REGISTRAR'S SIGNATURE Julia Gordon-Rubels					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or the

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

077615		JAN 11 1988		REG. NO. 87 35219	
1. DECEASED NAME (TYPE OR PRINT) HILDA EMANUEL HAYES				2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 31, 1987	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 7, 1905	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 82 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sylvan Manor Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4201 Dannel Lane		20895	
14. FATHER'S NAME FIRST MIDDLE LAST Sanford Emanuel		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Peters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 577-14-7593		17. INFORMANT ADDRESS Joan D. Price Niece Same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Indeterminate Sym.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3/4 12/31 1987		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE 12/31 1987	
22a. I certify that (I) (this hospital) attended the deceased from 3/4 12/31 1987 to 12/31 1987 , that (I) (we) last saw the deceased alive on 12/31 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.					
22b. SIGNATURE Myron L. Lenkin		DEGREE MD		22c. DATE SIGNED 1/1/88	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKIN MD		22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 4, 1988		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince George's Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins, Jr.		25a. DATE REC'D. BY REGISTRAR JAN 7 1988		25b. REGISTRAR'S SIGNATURE Julia S. [Signature]	
500 University Blvd., W. Silver Spring, Md. 20901					

0358-0-8530

JAN 7 1988

176287 DEC 28 1987

FOR
STATE
REGISTRAR

WALTER

R.

HELM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36220

1. DECEASED NAME (TYPE OR PRINT) WALTER R. Helm		2a. DATE OF DEATH MONTH DAY YEAR 12-18-87		2b. HOUR 1330M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH AUG. 18, 1905	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Switzerland		7b. CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS LAST BIRTHDAY) 82	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ENGINEER	
13a. STATE MD.		13b. COUNTY MONT.		13c. STREET ADDRESS / ZIP CODE 10543 Cambridge Ct. 20879	
14. FATHER'S NAME FIRST MIDDLE LAST ADOLF - HELM		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA - TRACHSLER		16. SOCIAL SECURITY NO. 547-28-9969	
17. INFORMANT ALICE R. HELM		18. ADDRESS SAME AS # 13		19. DATE OF OPERATION	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Multiple Myeloma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes days years		21. DATE OF OPERATION	
22. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CONTRIBUTING TO DEATH		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		26. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/17/87		27. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 15, PART 1 OR PART 2)	
28. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		29. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30. LOCATION CITY OR TOWN COUNTY STATE CHANNUTE NEOSHO KANSAS	
31. I certify that (I) (the hospital) attended the deceased from 12/10 , 19 87 , to 12/18 , 19 87 , that (I) (we) last saw the deceased alive on 12/17/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.		32. SIGNATURE Dr. Stephen Newman		33. DATE SIGNED 12/18/87	
34. PHYSICIAN'S NAME (TYPE OR PRINT) DR. STEPHEN NEWMAN		35. ADDRESS MONT. VILLAGE AVE. GAITHERSBURG, MD. 20879		36. DATE REC'D. BY REGISTRAR DEC 24 1987	
37. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		38. DATE DEC. 30, 1987		39. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK	
40. FUNERAL DIRECTOR NAME MURIEL H. BARBER		41. ADDRESS LAYTONSVILLE, MD. 20879		42. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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075943 DEC 28 1987

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 7 3 6 2 2 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FRANCES LEE HENDRICKS			2a. DATE OF DEATH MONTH DAY YEAR DECEMBER 16 1987		2b. HOUR P M 8:00		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 26 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS MONTHS DAYS HRS MIN.	
7a. BIRTHPLACE (CITY OR TOWN, COUNTY, STATE) DISTRICT OF COLUMBIA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST OWEN LEE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EMILY PATTERSON		13e. STREET ADDRESS / ZIP CODE 4500 MIDDLETON LANE 20814			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 1918-1919		17. INFORMANT ADDRESS 20817		17. INFORMANT ADDRESS 20817	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE INFERIOR WALL MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) ACUTE INFERIOR WALL MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 12 , 19 87 , to DECEMBER 16 , 19 87 , that (I) (we) last saw the deceased alive on DECEMBER 16 , 19 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Westby G. Fisher</i>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 17 DEC 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WESTBY G. FISHER, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL BETHESDA, MD 20814-5011					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 21, 1987		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc.		ADDRESS 300 West Montgomery Ave., Rockville, MD 20850		25a. DATE RECEIVED BY REGISTRAR DEC 22 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Gordon-Landack</i>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT)		FIRST D. MIDDLE Jane LAST Hendrickson		2b. DATE OF DEATH MONTH DAY YEAR		2c. HOUR	
D. JANE Hendrickson		12-7-87		12:30 A.M.					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Ct, Bethesda MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Receptionist		12b. KIND OF BUSINESS OR INDUSTRY Report US News & World			
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 9617 Bellevue Dr./20814	
14. FATHER'S NAME FIRST MIDDLE LAST Raymond --- Hendrickson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith --- Ulmer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-42-9958		17. INFORMANT ADDRESS M. Joseph Stoutenburgh, 1155 CT Ave, NW, Wash, DC					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>alveolar carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>9 mo</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that: (I) (this hospital) attended the deceased from Apr. 1, 1987, to Dec 6, 1987, that (I) (we) last saw the deceased alive on Dec 6, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) view the body after death.									
22b. SIGNATURE OF ATTENDING PHYSICIAN MO				22c. DATE SIGNED Dec. 7, 1987					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER G. PUSHKAS				22e. ADDRESS 11510 OLD GEORGETOWN RD. ROCKVILLE, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/8/87		23c. NAME OF CEMETERY OR CREMATORY Mt. Comfort Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, VA			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave, NW, Washington, D.C. 20016				25a. DATE REC'D. BY REGISTRAR DEC 11 1987		25b. REGISTRAR'S SIGNATURE Julia Tidwell-Rodman			

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Joseph Jewler's Sons, Inc.

5130 Wisconsin Ave., N.W., Washington, D.C. 20016

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 REG. NO. 30223

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edith M Herreshoff</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>12-3-87</i>		2b. HOUR <i>0848M</i>
3. SEX <i>Female</i>	4. RACE <i>C</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>10 28 1910</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>OHIO</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY MD</i>	
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>CALIFORNIA</i>	13b. COUNTY <i>ALAMEDA</i>	13c. CITY OR TOWN <i>BERKELEY</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <i>1708 EUCLID AVENUE 94709</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>CARL CHRISTIAN MEYER</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>ELSA SPRINGER</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>550-68-6725</i>		17. INFORMANT ADDRESS <i>JAMES B. HERRESHOFF/SON/SAME AS 13</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>Chronic emphysema with respiratory failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>45min</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>anemia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the XXXX) attended the deceased from <i>Dec. 2</i> 19 <i>87</i> to <i>Dec. 3</i> 19 <i>87</i> , that (I) (we) last saw the deceased alive on <i>Dec. 2</i> 19 <i>87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Redmond</i>				22c. DATE SIGNED <i>Dec 3, 1987</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>REARDONS MD</i>				22e. ADDRESS <i>914 LARCH AVE TAKOMA PARK MD</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>CREMATION</i>		23b. DATE <i>DEC 4, 1987</i>	23c. NAME OF CEMETERY OR CREMATORY <i>METROPOLITAN CREMATORY ALEXANDRIA</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>VIRGINIA</i>
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS, JR.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 11 1987</i>		
500 UNIVERSITY BLVD W SILVER SPRING, MD 20901			25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOV 11 1951

[Faint, mostly illegible handwritten text across the page, possibly a ledger or account book.]

NOV 11 1951

38- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 36224

1. DECEASED NAME (TYPE OR PRINT) Catherine		FIRST MIDDLE LAST Higgins		2a. DATE OF DEATH MONTH DAY YEAR 12-26-87		2b. HOUR 7A	
3. SEX F		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 06-07-94		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS. 6 MONTHS 19 DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Circle Manor Neg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE D.C.		13b. COUNTY Wash DC		13c. CITY OR TOWN Wash DC		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Patrick Higgins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Gislis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. Unknown	
17. INFORMANT G. Satka		18. ADDRESS field on 10231 Carroll Pl.		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary arrest DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/21/86 to 12/26/87 , that (he/she) last saw the deceased alive on 12/26/87 , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE B.N. Rosebaum, M.D. DEGREE M.D.				22c. DATE SIGNED 12/26/87		22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.N. ROSEBAUM	
22e. ADDRESS 3720 FARRAGUT AVE KENSINGTON, MD 20891				22f. DATE REC'D. BY REGISTRAR DEC 31 1987			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 12-26-87		23c. NAME OF CEMETERY OR CREMATORY Georgetown Univ Med Sch		23d. LOCATION CITY OR TOWN COUNTY STATE Washington DC	
24. FUNERAL DIRECTOR NAME Robert C. Mason Funeral Home, Inc. ADDRESS 				25. REGISTRAR'S SIGNATURE John D. Rader			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and they should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

DHMH - 16 60M 7/84
(VRA 15, 4)

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

3 6 2 2 5

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			7b. HOUR		
FIRST MIDDLE LAST JOSEPH JOHN HILTON			MONTH DAY YEAR DECEMBER 6 1987			P M 3:40		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		8. IF UNDER 74 HRS
MALE	CAUCASIAN	MONTH DAY YEAR JUNE 6 1912		75 YRS		MONTHS DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
NEW YORK	USA			MONTGOMERY MD				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	BETH. NAVAL HOSPITAL			INSPECTOR		HEALTH & HUMAN		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE				
MARYLAND	MONTGOMERY	KENSINGTON	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20895 SVCS 3333 UNIVERSITY BLVD #906				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
LOUIS WALSH HILTON			MARGARET MARY COTTER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
YES		1932-1955		MARGARET HILTON, 3333 UNIVERSITY BLVD 20895				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UROSEPSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MULTIINFARCT DEMENTIA DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from DECEMBER 5, 19 87, to DECEMBER 6, 19 87, that (I) (we) last saw the deceased alive on DECEMBER 6, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE W. G. FISHER, LT. MC, USN				DEGREE MD			22c. DATE SIGNED 7 DEC 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				
				NAVAL HOSPITAL BETHESDA, MD 20814-5011				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
CREMATION		DEC 7, 1987		METROPOLITAN CREMATORY		ALEXANDRIA VIRGINIA		
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS, JR. 500 UNIVERSITY BLVD W SILVER SPRING, MD 20901				DEC 14 1987		John Dearden-Randall		

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked unknown, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36226

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mabel R. Hoesterey			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1987		2b. HOUR 2215 M
3 SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR February 27, 1902		6 AGE (IN YEARS (LAST BIRTHDAY)) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? United States	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 303 Adclaire Road/ 20850
14 FATHER'S NAME FIRST MIDDLE LAST Not Available Rottach		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Gardner			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 073-09-1537 B		17 INFORMANT ADDRESS Anne H. Kreps (Daughter) 246 St. Antons Way Arnold, Maryland 21012	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Abdominal Catastrophy (Acute Abdomen)</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/24</u> , 19 <u>82</u> , to <u>12/17</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Frauke Westphal M.D.				22c. DATE SIGNED Dec. 18, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M.D.				22e. ADDRESS 809 Viers Mill Road, Rockville, Maryland 20850	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE December 19, 1987	23c. NAME OF CEMETERY OR CREMATORY Montgomery Crematorium Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Bethesda/Montgomery/Maryland
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Home/ Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850			25a. DATE REC'D. BY REGISTRAR DEC 22 1987		
			25b. REGISTRAR'S SIGNATURE Jia Gordon-Randall		

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George Washington

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DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

B 7 REG. NO. 86227

1. DECEASED NAME (Type in print) FIRST MIDDLE LAST CHARLOTTE G. HOGAN			2a. DATE OF DEATH MONTH DAY YEAR 12-26-87			2b. HOUR 10 ³⁵ A M					
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11-22-11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (If not in such facility, give street address) Holy Cross Hospital				12a. USUAL OCCUPATION (Type of work for most of working life) Ret. Legal Sec.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9913 Indian Lane 20901		
14. FATHER'S NAME FIRST MIDDLE LAST Samuel G. Gaither			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Alice Binger								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (If yes, give war or dates) N/A		17. INFORMANT ADDRESS John G. Hogan-son-(same as 13e)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>PARKINSONISM; DEHYDRATION; PNEUMONITIS</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in item 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> , 19 <u>87</u> , to <u>Dec 26</u> , 19 <u>87</u> , that the (we) last saw the deceased alive on <u>Dec 26</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Bernard A. Fitzgerald</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-26-87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD						22e. ADDRESS 217 UNIVERSITY BLVD E, SILVER SPRING, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-29-87		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Georges Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silt. Spr. Md. 20904						25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Gordon-Radner</u>			

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36228

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Helen Mc Carthy Holman			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1987		2b. HOUR 950am		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Feb. 13, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) teacher		12b. KIND OF BUSINESS OR INDUSTRY P.G. County Schools	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Bowie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Timothy McCarthy		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Durkin		13e. STREET ADDRESS 20715 9112 West Chestnut Ave.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-38-2011		17. INFORMANT 7720 Tremayne Place, #304 Edward B. Holman, McLean, Va. 22102			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Maximize MI. DUE TO, OR AS A CONSEQUENCE OF (c) Stroke, Colon Ca. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Stroke, Colon Ca.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 MINS.	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NA			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 12/12 87 12/12 87			
22. I certify that (I) (this hospital) attended the deceased from 12/12 87 to 12/12 87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.						22c. DATE SIGNED 12/14/87	
22b. SIGNATURE [Signature]		DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ravi Yassir MD		22e. ADDRESS 11141 Georgia Ave. Ste 107 Whitman, MD. 20902					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORY Bloomfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE New Bloomfield, Perry, Pa.	
24. NAME OF FUNERAL HOME OR NAME ADDRESS FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 Baltimore Ave., Hyattsville, Maryland				25. DATE REC'D. BY REGISTRAR DEC 22 1987		26. REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Coronary notified 10

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 6 2 2 9

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	7a. DATE KNOWN OF DEATH		7b. DATE OF DEATH	7c. DATE OF DEATH	7d. DATE OF DEATH	7e. DATE OF DEATH	7f. DATE OF DEATH	7g. DATE OF DEATH	7h. DATE OF DEATH	7i. DATE OF DEATH	7j. DATE OF DEATH	7k. DATE OF DEATH	7l. DATE OF DEATH	7m. DATE OF DEATH	7n. DATE OF DEATH	7o. DATE OF DEATH	7p. DATE OF DEATH	7q. DATE OF DEATH	7r. DATE OF DEATH	7s. DATE OF DEATH	7t. DATE OF DEATH	7u. DATE OF DEATH	7v. DATE OF DEATH	7w. DATE OF DEATH	7x. DATE OF DEATH	7y. DATE OF DEATH	7z. DATE OF DEATH																																																																																																																																																																
AUSTIN		K.	HOLT	11-13-87		11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87																																																																																																																																																																
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7a. DATE KNOWN OF DEATH	7b. DATE OF DEATH	7c. DATE OF DEATH	7d. DATE OF DEATH	7e. DATE OF DEATH	7f. DATE OF DEATH	7g. DATE OF DEATH	7h. DATE OF DEATH	7i. DATE OF DEATH	7j. DATE OF DEATH	7k. DATE OF DEATH	7l. DATE OF DEATH	7m. DATE OF DEATH	7n. DATE OF DEATH	7o. DATE OF DEATH	7p. DATE OF DEATH	7q. DATE OF DEATH	7r. DATE OF DEATH	7s. DATE OF DEATH	7t. DATE OF DEATH	7u. DATE OF DEATH	7v. DATE OF DEATH	7w. DATE OF DEATH	7x. DATE OF DEATH	7y. DATE OF DEATH	7z. DATE OF DEATH																																																																																																																																																																
Female	White	July 14 1987	3	30	30	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87	11-13-87																																																																																																																																																																
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. KIND OF BUSINESS OR INDUSTRY		13. CITY OR TOWN		14. STATE		15. COUNTY		16. CITY OR TOWN		17. STREET ADDRESS		18. INSIDE CITY LIMITS?		19. MOTHER'S MAIDEN NAME		20. FATHER'S NAME		21. WAS DECEASED EVER IN U.S. ARMED FORCES?		22. SOCIAL SECURITY NO.		23. INFORMANT		24. ADDRESS																																																																																																																																																															
Maryland	U.S.A.	WIDOWED	Montgomery County	=====		Shady Grove Hospital		=====		Gaithersburg		Maryland		Montgomery		Gaithersburg		23 Gold Kettle Court 20878		NO		Janet C. Quenon		Paul J. Holt		No		=====		Paul J. Holt		Same as 13e																																																																																																																																																															
10. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden infant death syndrome</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																																																																																																																																																																																															
19a. DATE OF OPERATION																																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																																20. AUTOPSY?																																																																																																																															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH																																21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19																																21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)																																																																																																																															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK																																21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																																21f. LOCATION STREET CITY OR TOWN COUNTY STATE																																																																																																																															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																																																																																																																																																																																															
ACTUAL SIGNATURE <u>Charles P. Kokes</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-14-87																																																																																																																																																																																															
EXAMINER'S NAME (TYPE OR PRINT) Charles P. Kokes, M.D. ADDRESS 111 Penn Street																																																																																																																																																																																															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation																																23b. DATE 11/15/87																																23c. NAME OF CEMETERY OR CREMATORY Westview Memorial Park																																23d. LOCATION CITY OR TOWN Catonsville																																COUNTY Balto																																STATE Md																															
24. FUNERAL DIRECTOR NAME George J. Gonce ADDRESS 4001 Ritchie Hwy Balto Md																																25a. DATE REC'D. BY REGISTRAR NOV 19 1987																																25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall																																																																																																																															

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

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Release by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 3 6 2 3 0

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Laura E. Hopkins			2a. DATE OF DEATH MONTH DAY YEAR Dec. 27, 1987		2b. HOUR 11:03PM
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR Apr. 18 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Derwood	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6108 Granby Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Bookkeeping
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Derwood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Edwin Elwell		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fairbanks		13e. STREET ADDRESS / ZIP CODE 6108 Granby Rd. Derwood Md. 20855	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-30-3236		17. INFORMANT ADDRESS Willard Hopkins 3104 E. Camelback Rd. 85016	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Acute Cerebral vascular accident					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 hours
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					5-10 years
DUE TO, OR AS A CONSEQUENCE OF (b). Cerebral Arteriosclerosis					
DUE TO, OR AS A CONSEQUENCE OF (c).					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: COPD, Bronchial Asthma					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from March 1985, to Oct. 29 1987, that (I) (we) last saw the deceased alive on Oct. 29 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Ruben C. Cosca, M.D.				22c. DATE SIGNED Dec. 28, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben C. Cosca, M.D.				22e. ADDRESS 17529 Redland Rd., Derwood, Md. 20855	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-87		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
23d. LOCATION CITY OR TOWN Baltimore, Maryland		23e. COUNTY		23f. STATE	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home		24b. ADDRESS 4401 Belair Rd. BALTO. MD. 21206		25a. DATE REC'D. BY REGISTRAR DEC 30 1987	
25b. REGISTRAR'S SIGNATURE					

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Handwritten notes and signatures, including a large signature at the bottom right.

100% COTTON

DEC 20 1951

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 3 6 2 3 1

1- FOR STATE REGISTRAR		DECEASED NAME (LAST OR PRINT) <i>Louis</i>		FIRST <i>Horowitz</i>		LAST		2a. DATE KNOWN OF DEATH ESTI MATED <i>DEC 3 1987</i>		2b. HOUR <i>A</i>	
3 SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>March 30 1919</i>	6 AGE (IN YEARS LAST BIRTHDAY) <i>68</i> YRS.	7. IF UNDER 1 YR. MONTHS DAYS	7. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>DEC 7 1987</i>		2d. HOUR <i>6:40</i>		2e. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Russia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.					
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9700 MD. Pkwy 4440</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Attorney</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Law</i>					
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Silver Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>9729 Mt. Pugh Rd Apt 402</i>			
14. FATHER'S NAME FIRST <i>Samuel</i> MIDDLE <i>Horowitz</i> LAST <i>Jenny</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Jenny</i> MIDDLE <i>Groont</i> LAST <i>Silver Spring</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>220-34-4894</i>		17. INFORMANT <i>Terry Horowitz</i> ADDRESS <i>11900 Viewcrest Tr.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		MEDICAL EXAMINER				DATE SIGNED <i>Dec 7 1987</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS, M.D.</i>		ADDRESS <i>1919 SEMINARY, S.S., MD.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/09/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Lebanon Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi, Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Ives-Pearson F.H., Falls Church, VA</i>		ADDRESS <i>472 N. Washington</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 09 1987</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL- TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

074667 DEC 10 1987

054007 DEC 10 01

DEC 09 01

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36232

FOR
1 - STATE
REGISTRAR

076315 DEC 25 87

1. DECEASED NAME (LAST, FIRST, MIDDLE) CARMEN M HORSFORD			2a. DATE OF DEATH MONTH DAY YEAR 12/23/87		2b. HOUR 0026 AM
3. SEX F	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 4 9 1912		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Indies	7b. CITIZEN OF WHAT COUNTRY? Pern. Resident	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SINGLE FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Clerk-Banta Grocery		12b. KIND OF BUSINESS OR

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Mont.	13c. CITY OR TOWN S.S.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 9090 Piney Branch Road 20903
14. FATHER'S NAME Unknown			15. MOTHER'S MAIDEN NAME Elizabeth Kennington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT Marion Manwarren (Niece (Same as 13E))		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic renal insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cachexia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
---	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Cachexia did not eat for several days</i>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 12/22/87 1987 to 12/22 1987, that (I) (we) last saw the deceased alive on 12/22/87 1987 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

22b. SIGNATURE <i>Michael A. Rodriguez</i>	DEGREE M.D.	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael A. Rodriguez</i>		22e. ADDRESS <i>831 University Blv. S. Spring Md 20903</i>

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 12/24/87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alex. Va.	23d. LOCATION CITY OR TOWN COUNTY STATE
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24. FUNERAL DIRECTOR NAME Hines/Rinaldi 11800 New Hamp Ave. S.S. Md.	25. DATE REC'D. BY REGISTRAR DEC 28 1987	26. REGISTRAR'S SIGNATURE <i>Julia Donahoe-Rodriguez</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05 03 12 DEC 50 21

UNITED STATES GOVERNMENT
OFFICE OF THE SECRETARY OF THE ARMY

12 10 1950

8 1 1950

TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text.]

12 10 1950

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. 36233

FOR
1- STATE
REGISTRAR

076217 DEC 28 1987

DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	21. HOUR		
Mary J. Howe						ESTIMATED		Dec. 21	1987		8:00 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	23. HOUR
Female	Cauc.	May 1, 1931	56 YRS.	MONTHS		DAYS		12 21 1987					8:00 AM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Massachusetts			United States			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Gaithersburg			#2 Culligan Drive			Stenographer			FBI				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS				
Maryland			Montgomery			Gaithersburg			Cullinan Drive 20878				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
Patrick O'Leary			Mary Ellis										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS							
no			026-22-9381			Thomas Howe, same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION													
DUE TO, OR AS A CONSEQUENCE OF													
(b) ARTEROSCLEROTIC CARDIOVASCULAR DISEASE													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
			AM. 12 21 1987			Found in Bed							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION							
			Home			2 CULLINAN DR GAITHERSBURG MONT MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED							
Francis C. Mayle, M.D.			Deputy			Dec. 22, 1987							
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS										
Francis C. Mayle, M.D.			Bethesda, Maryland 20814										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION				
Burial						New Calvary Cemetery			Brighton, Massachusetts				
24. FUNERAL DIRECTOR NAME													
Robert A. Pumphrey Funeral Home/ Rockville, Inc.													
300 West Montgomery Ave. Rockville, MD 20850													
25c. DATE REC'D. BY REGISTRAR													
DEC 24 1987													
25b. REGISTRAR'S SIGNATURE													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

11:00 AM 11/10/50

20% COTTON FIBER

CLINTON W. BIRD

074855 DEC 14 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 35234

2. DECEASED NAME (TYPE OR PRINT) Daphne D. Howerton			2a. DATE OF DEATH MONTH DAY YEAR 12-08-87		2b. HOUR 6:50 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 06 30 03		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Postmaster		12b. KIND OF BUSINESS OR INDUSTRY USPoatal Sv.
13a. STATE Missouri	13b. COUNTY Macon Cty.	13c. CITY OR TOWN Elmer	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Main Street, 62538	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Mathis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mora Scott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 487-30-0586	17. INFORMANT ADDRESS Wilmeta E. Holladay 12115 Otis Drive Rockville, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Brain Tumor (Astrocytoma) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from July 30, 1987, to December 8, 1987, the (1) (no) last saw the deceased alive on December 7, 1987, and that in my (my) (our) opinion death occurred on the date and hour and from the causes stated above (If we had not view the body after death).					
22b. SIGNATURE Jeffrey M. Crane MD		DEGREE MD		22c. DATE SIGNED 8 Dec 87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY M. CRANE		22e. ADDRESS 14801 Physicians Lane #271 Rockville, MD 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/12/87	23c. NAME OF CEMETERY OR CREMATORY Bell Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Elmer, Missouri		
24. FUNERAL DIRECTOR NAME Tyson - Wheeler		24b. ADDRESS 1331 Rockville Pike Rockville, Md. 20852		25. DATE REC'D. BY REGISTRAR DEC 11 1987	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

1. The first part of the report is a summary of the work done during the last year.

2. The second part is a detailed account of the experiments carried out.

3. The third part is a discussion of the results obtained and a comparison with previous work.

4. The fourth part is a conclusion and a list of references.

5. The fifth part is a list of the names of the people who have helped in the work.

6. The sixth part is a list of the names of the people who have read the report.

7. The seventh part is a list of the names of the people who have approved the report.

8. The eighth part is a list of the names of the people who have signed the report.

9. The ninth part is a list of the names of the people who have read the report.

10. The tenth part is a list of the names of the people who have approved the report.

11. The eleventh part is a list of the names of the people who have signed the report.

12. The twelfth part is a list of the names of the people who have read the report.

13. The thirteenth part is a list of the names of the people who have approved the report.

14. The fourteenth part is a list of the names of the people who have signed the report.

15. The fifteenth part is a list of the names of the people who have read the report.

16. The sixteenth part is a list of the names of the people who have approved the report.

17. The seventeenth part is a list of the names of the people who have signed the report.

18. The eighteenth part is a list of the names of the people who have read the report.

077318 JAN -7 00

 item 6 G635 1-6-88 sb
 FOR STATE per funeral home
 REGISTRAR

 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

REG. NO. 8 7 3 6 2 3 5

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FELIPE B. HUAMAN			2a. DATE OF DEATH MONTH DAY YEAR 12 23 87		2b. HOUR 3:35 am
3. SEX MALE	4. RACE Hispanic	5. DATE OF BIRTH MONTH DAY YEAR Aug. 14 1913		6. AGE (IN YEARS LAST BIRTHDAY) 74 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) COUNTRY Peru	7b. CITIZEN OF WHAT COUNTRY? So. Amer.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Doctor's Ass't		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.		13b. COUNTY Montg.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12807 Academy Way, Apt 1 20852
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sofia Davila			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Amparo Huaman (daughter) same AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiorespiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 50 min 15 hrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 12-22 19 87 to 12-23 19 87, that (I) (we) last saw the deceased alive on 12-23 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas G. Sinderson, MD		DEGREE		22c. DATE SIGNED 12-23-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS G. SINDERSON, MD		22e. ADDRESS 11125 ROCKVILLE PIKE, ROCKVILLE MD. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12-28-87	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Montg. MD	
24. FUNERAL DIRECTOR NAME ADDRESS George R. Snowden Rockville, MD 20850		25a. DATE REC'D. BY REGISTRAR DEC 28 1987		25b. REGISTRAR'S SIGNATURE A. R. Rinderson-Burke	

MEDICAL CERTIFICATION

229

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked for item 18 shows only injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36236

1. DECEASED NAME (TYPE OR PRINT) FIRST Henry MIDDLE S. LAST Huggins <i>Henry Huggins</i>			2a. DATE OF DEATH MONTH 12 DAY 05 YEAR 87 2b. HOUR 2:25A		
3. SEX M Male		4. RACE white		5. DATE OF BIRTH MONTH 10 DAY 24 YEAR 06	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS (LAST BIRTHDAY)) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-employed		12b. KIND OF BUSINESS OR INDUSTRY Hardware Store			
13a. STATE DC		13b. COUNTY N/A		13c. CITY OR TOWN Wash.	
14. FATHER'S NAME FIRST John MIDDLE Gaston LAST Huggins		15. MOTHER'S MAIDEN NAME FIRST Barbara R. MIDDLE Huggins LAST Snyder		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 579-03-3240	
17. INFORMANT Barbara R. Huggins		ADDRESS 13803 Parkland Dr.		18. CITY OR TOWN Rockville MD	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septis Conditions, if any, which gave rise to immediate cause: (c), stating the underlying cause last. Renal failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a perforated peptic ulcers, congestive heart failure			
19a. DATE OF OPERATION 11/6/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED perforated peptic ulcers	19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH 11 DAY 16 YEAR 1987	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 11c, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 11/16 1987 to 12/5 1987 , that (I) (we) lost saw the deceased alive on 12/4 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Bradley H Bennett		22c. DEGREE MD	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bradley H Bennett		22e. ADDRESS 1019 19th St. N.W. Suite 520 Washington DC 20036	
22f. DATE SIGNED 12/6/87		22g. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/9/87	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cem.	23d. LOCATION CITY OR TOWN Rockville, MD COUNTY STATE
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 WI Ave. NW Wash., DC 20016			25. DATE REC'D. BY REGISTRAR DEC - 9 1987

DEC 1953

07/12/1953

Henry

John

U.S.A.

Self-employed

2325 Northampton St. NW 20035

Wash. D.C.

John

Rockville, MD 20853

Arthur

Frederick

Barton

John

Robert W. Perkins 1805 Perkins Dr.

222-07-3240

John

Rockville, MD

Frederick

Frederick

Frederick

Rockville, MD 20853

DEC 1953

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATHFOR
1. STATE
REGISTRAR

REG. NO.

36237

076760 DEC 31

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
Theodore Joseph Hurley

2a. DATE OF DEATH MONTH DAY YEAR
12-25-87

2b. HOUR MIN
11:20 PM

3. SEX Male

4. RACE White

5. DATE OF BIRTH MONTH DAY YEAR
1 9 1911

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN
76 1 12 0 0

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania

7b. CITIZEN OF WHAT COUNTRY? U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.

10. CITY OR TOWN OF DEATH Bethesda

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer

12b. KIND OF BUSINESS OR INDUSTRY Pa. St. Govt.

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
Md. Montgomery Rockville

13b. INSIDE CITY LIMITS? YES ☒ NO ☐

13c. STREET ADDRESS / ZIP CODE 14427 Woodcrest Dr / 20853

14. FATHER'S NAME FIRST MIDDLE LAST
Timothy J. Hurley

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Mensch

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO

16b. SOCIAL SECURITY NO. 195-20-9886

17. INFORMANT ADDRESS
Theodore Steiger Rockville, Md 20853

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ AT WORK ☐ NOT WHILE ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (1) (this hospital) attended the deceased from 21 Dec 1987 to 25 Dec 1987, that (1) (we) lost the deceased alive on 25 Dec 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE Paul T. Noone

22c. DATE SIGNED 25 Dec 87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul T. Noone

22e. ADDRESS 50 W. Edmonston Dr. Rockville, Md. 20852

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

23b. DATE 12/30/87

23c. NAME OF CEMETERY OR CREMATORY Cherry Grove Cemetery Nordmont Pa.

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME Tyson Wheeler F.H. ADDRESS 1331 Rockville Pk Rockville, Md.

25a. DATE REC'D. BY REGISTRAR DEC 30 1987

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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Rockville, Md.

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FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36238

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elva Parsons Hyatt			2a. DATE OF DEATH MONTH DAY YEAR 12 08 87		2b. HOUR 0255 AM
3. SEX female	4. RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan 30, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR WHICH WORKING LIFE) Medical clerk	12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS / ZIP CODE 3300 Benson Av., 21227	
14. FATHER'S NAME FIRST MIDDLE LAST George Parsons		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Drain			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 030 07 0965	17. INFORMANT ADDRESS Marsha H. DeWeese, 13407 Country Ridge Dr., Germantown, Md. 20874		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>advanced emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Cancer of the lung</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE Dec 7 87 Dec 7 87	
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 7 19 87</u> to <u>Dec 7 19 87</u> , that (I) (we) last saw the deceased alive on <u>Dec 7 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) read and view the body after death.					
22b. SIGNATURE <u>[Signature]</u>		DEGREE		22c. DATE SIGNED <u>12/8/87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARIO S. SELEIDANE		22e. ADDRESS 14816 Physicians Lane Rockville Md. 20854			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 11, 1987	23c. NAME OF CEMETERY OR CREMATORY Whitemarsh Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Ambler Pennsylvania
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Av., Rockville, Md. DEC 11 1987					

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36239

1 - FOR
STATE
REGISTRAR

DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
HELEN S. IDLE

2a DATE OF DEATH MONTH DAY YEAR
DECEMBER 31, 1987 2b HOUR
6:55AM

3. SEX **Female** 4. RACE **White** 5. DATE OF BIRTH MONTH DAY YEAR
Aug. 9, 1905

6. AGE (IN YEARS LAST BIRTHDAY) **82** YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) **New York** 7b CITIZEN OF WHAT COUNTRY? **U.S.A.** 8 MARRIED NEVER MARRIED ☐
WIDOWED ☒ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH **Montgomery County** MD

10 CITY OR TOWN OF DEATH **Gaithersburg** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
SHADY GROVE ADVENTIST NURSING CENTER 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Homemaker** 12b KIND OF BUSINESS OR INDUSTRY **Home**

13a STATE **Maryland** 13b COUNTY **Montgomery** 13c CITY OR TOWN **Gaithersburg** 13d INSIDE CITY LIMITS? YES ☒ NO ☐ 13e STREET ADDRESS / ZIP CODE **8700 Walkers Choice Rd./20760**

14 FATHER'S NAME FIRST MIDDLE LAST **Roland R. Singer** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Emma A. Bush**

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) **No** 16b SOCIAL SECURITY NO. **264-50-3475B** 17. INFORMANT ADDRESS **817 Goldsborough Dr. Dunning Idle IV (Son) Rockville, Md. 20850**

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Aspiration Pneumonia** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Days -

DOE TO, OR AS A CONSEQUENCE OF
(b) **Cerebral Vascular Accident** **Weeks**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(c) **Atherosclerotic Peripheral Vascular disease** **Years**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Ischemic heart disease, Chronic Congestive Heart Failure, Atrial Fibrillation

19a DATE OF OPERATION 19b CONDITION FOR WHICH OPERATION WAS PERFORMED 20a AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR
19 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d INJURY OCCURRED 21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) 21f LOCATION STREET CITY OR TOWN COUNTY STATE

22a I certify that (I) (the hospital) attended the deceased from **March**, 19**86**, to **December 31**, 19**87**, that (I) (we) last saw the deceased alive on **12/29**, 19**87**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE **Byrd O. Johnson** DEGREE **MO** ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c DATE SIGNED **12/31/87**

22d PHYSICIAN'S NAME (TYPE OR PRINT) **BYRD O. JOHNSON** 22e ADDRESS **911 N. Russell Ave. Gaithersburg, Md. 20879**

23a BURIAL, CREMATION, REMOVAL (SPECIFY) **Cremation** 23b DATE **Jan/2/88** 23c NAME OF CEMETERY OR CREMATORY **Chambers Crematory** 23d LOCATION CITY OR TOWN COUNTY STATE
Riverdale, P.G. Co., Maryland

24 FUNERAL DIRECTOR NAME ADDRESS **Chambers Funeral Home Silver Spring, Maryland** 25a DATE REC'D. BY REGISTRAR **JAN 11 1988** 25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them within 10 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with a 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 36240

1. DECEASED NAME (TYPE OR PRINT) Constance R. Jackson				2a. DATE OF DEATH MONTH DAY YEAR 12 13 87		2b. HOUR 1720 M		
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 63		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Edward W. Rounds		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Eberhardt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-24-8005		17. INFORMANT Bethesda, Md. 20817 Katherine Irvine (sister) 6004 Walton Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Melanotic Breast Cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yes.								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) was did not attend the deceased from 11/30 19 87 to 12/13 19 87 that (I) was did not view the deceased alive on 12/7 19 87 , and that in (my) own own opinion death occurred on the date and hour and from the causes stated above. (I) did did not view the body after death.								
22b. SIGNATURE Stephen J. Newman				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/14/87		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen J. Newman				22e. ADDRESS 19261 Montgomery Village Ave. Gaithersburg, Md. 20879				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12/16/87		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory Alexandria, Virginia		23d. LOCATION (CITY OR TOWN) STATE		
24. FUNERAL DIRECTOR NAME ADDRESS Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR DEC 23 1987		25b. REGISTRAR'S SIGNATURE [Signature]		

BP _____

0501 17 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 REG. NO. 3 5 2 4 1

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH JACOBS		2a. DATE OF DEATH MONTH DAY YEAR 12 26 87		2b. HOUR 7¹⁵ AM	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 8 25 19 68	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12613 LITTLETON ST.		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON	
14. FATHER'S NAME FIRST MIDDLE LAST LOUIS STARKOFF		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LITZA RABINOWITZ		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 124-10-1070		17. INFORMANT HUSBAND LOUIS H. JACOBS: 12613 LITTLETON ST.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>endometrial carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>coronary artery disease</u>					
19a. DATE OF OPERATION July 19 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED coronary artery disease		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE WHEATON MONTGOMERY MD	
22a. I certify that (I) (this hospital) attended the deceased from <u>July 19 83</u> to <u>December 26 19 87</u> , that (I) (we) lost saw the deceased alive on <u>November 18 19 87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.					
22b. SIGNATURE <u>Michael Lincoln</u>				22c. DATE SIGNED 12/26/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Lincoln M.D.				22e. ADDRESS 10313 Georgia Ave. Silver Spring MD 20902	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/28/87		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GDN.	
23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH VIRGINIA		25a. DATE REC'D. BY REGISTRAR DEC 31 1987			
24. FUNERAL DIRECTOR'S NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS		25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>			
1170 ROCKVILLE PIKE; ROCKVILLE, MD 20852					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove column pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy requested.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 7 3 6 2 4 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harold L. Jenkins				2a. DATE OF DEATH MONTH DAY YEAR December 20, 1987		2b. HOUR 8:00PM	
3 SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR February 13, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Asst. Chief of Information		12b. KIND OF BUSINESS OR INDUSTRY Soil Conservation Service	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Eldridge Kader Jenkins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vessie B. Wilson		13e. STREET ADDRESS / ZIP CODE 4757 Chevy Chase Dr., /20815			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT (Nephew) 1-12 Kemeys Cove Richard W. Murray Scarborough, N.Y. 10510			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Anemia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months 10 years 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/18/85</u> , 19 <u>87</u> , to <u>12/21</u> , 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Eva M. Morell</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED December 21, 1987	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eva M. Morell, M.D.				22e. ADDRESS 6000 Executive Blvd. Rockville, Md. 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 23, 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home Bethesda, Inc. 7557 Wisconsin Av., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 24 1987		25b. REGISTRAR'S SIGNATURE <i>John E. ...</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 36243

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucile M. Jenkins			2a. DATE OF DEATH MONTH DAY YEAR 12 18 87		2b. HOUR 12¹⁵ A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR October 22, 1910		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Dakota		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County, MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Clerk		12b. KIND OF BUSINESS OR INDUSTRY Retail				

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4757 Chevy Chase Drive/20815	
14. FATHER'S NAME FIRST MIDDLE LAST Eldridge Kader Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vessie B. Wilson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 541 32 4550		17. INFORMANT ADDRESS Richard W. Murray 1-12 Kemeys Cove Scarborough, New York 10510						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sepsis Pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) Organic Brain Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:0		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from August 28, 1987 , to December 18, 1987 , that (I) (we) last saw the deceased alive on Dec 18 1987 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) (b) (c) (d) (e) view the body after death.							
22b. SIGNATURE Boo K. Kim				DEGREE MD		22c. DATE SIGNED 12/18/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Boo K. Kim				22e. ADDRESS 8921 Slady Grove Court, 20817			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE December 23 1987		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc.				25. DATE REC'D BY REGISTRAR DEC 24 1987			
26. ADDRESS 7557 Wisconsin Ave. Bethesda, Maryland				27. REGISTRAR'S SIGNATURE			

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UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR

GEOLOGICAL SURVEY

056214-0001



077108 JAN 5 1988

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

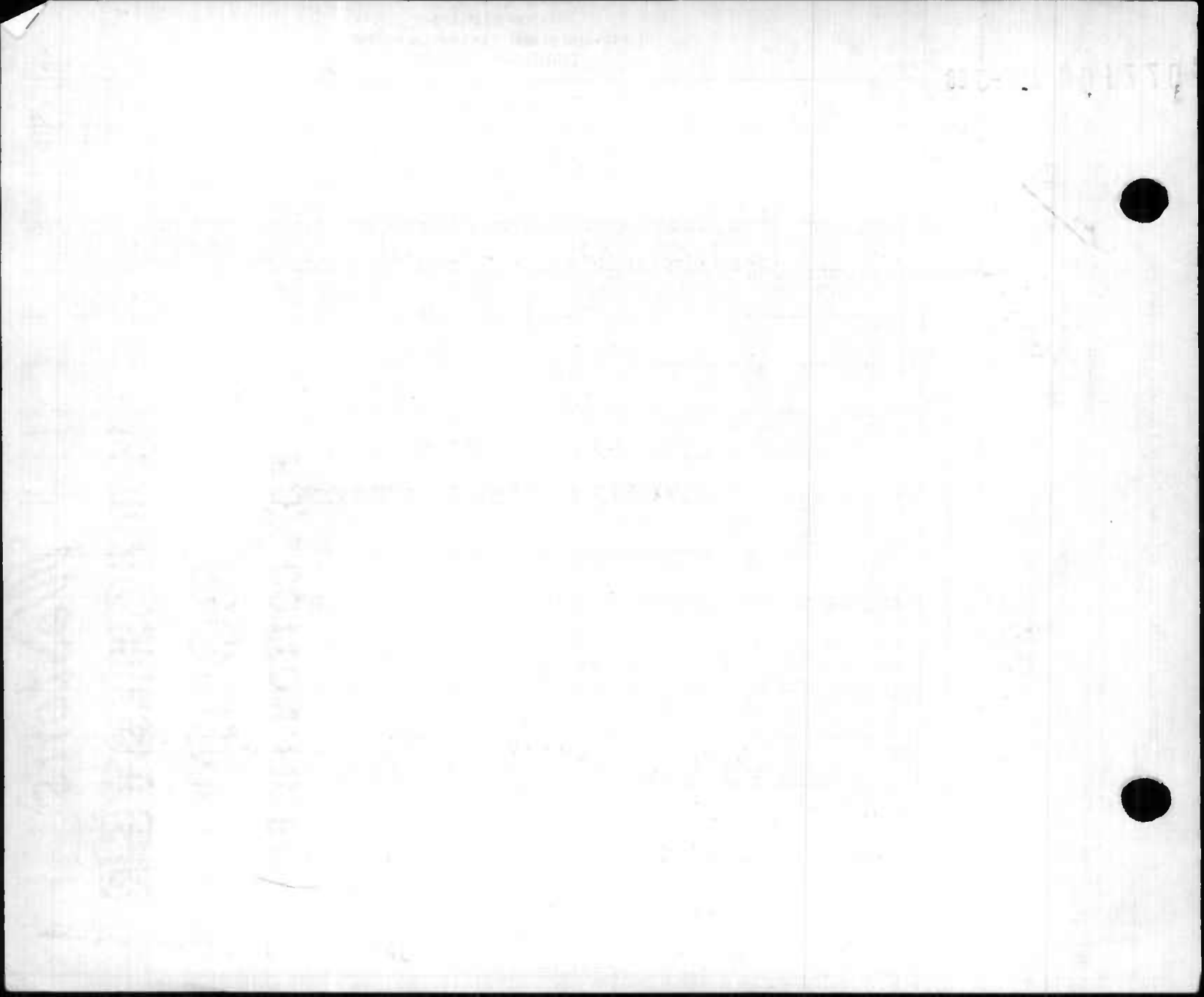
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) Helen A. Jespersen				2b. DATE OF DEATH MONTH DAY YEAR 12-30-87		2c. HOUR 1100AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 17, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School Teacher		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1711 Farragut Avenue/20851	
14. FATHER'S NAME FIRST MIDDLE LAST Maurice J. Archbold		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude Mosher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 483 64 7690		17. INFORMANT ADDRESS Charles F. Jespersen, Sr. same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) VALVULAR HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12/30/87 to 12/30/87 , that (I) (we) last saw the deceased alive on 12/30/87 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Mark F. Weinstein MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/30/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARK F. WEINSTEIN MD		22e. ADDRESS 11155 Rockville Pike Rockville MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan 4, 1988		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home/ Rockville, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE [Signature]			
300 West Montgomery Ave. Rockville, MD 20850									

BP



075069 DEC 15 1987

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

87

REG. NO. 36245

1. DECEASED NAME (TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE OF DEATH MONTH DAY YEAR

2b. HOUR

3. SEX

4. RACE

5. DATE OF BIRTH MONTH DAY YEAR

6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

10. CITY OR TOWN OF DEATH

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS? YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

14. FATHER'S NAME FIRST MIDDLE LAST

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

16b. SOCIAL SECURITY NO.

17. INFORMANT ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) (b) (c) DUE TO, OR AS A CONSEQUENCE OF

CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (the hospital) attended the deceased from above, (I) (we) (did not) view the body after death.

22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION CITY OR TOWN COUNTY STATE

24. FUNERAL DIRECTOR NAME ADDRESS

25a. DATE REC'D. BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 7/84 (VRA 15, 4)

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